

DOMESTIC VIOLENCE AS A PUBLIC HEALTH ISSUE

HEARING
BEFORE THE
HUMAN RESOURCES AND INTERGOVERNMENTAL
RELATIONS SUBCOMMITTEE
OF THE
COMMITTEE ON
GOVERNMENT OPERATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
SECOND SESSION

OCTOBER 5, 1994

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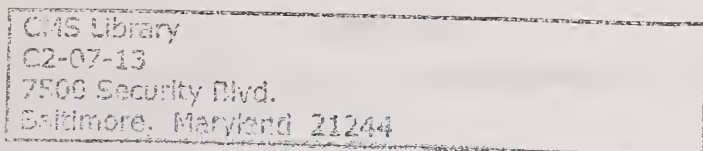
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DOMESTIC VIOLENCE AS A PUBLIC HEALTH ISSUE

WEDNESDAY, OCTOBER 5, 1994

HOUSE OF REPRESENTATIVES,
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:01 a.m., in room 2247, Rayburn House Office Building, Hon. Edolphus Towns (chairman of the subcommittee) presiding.

Present: Representatives Edolphus Towns, Thomas M. Barrett, and Steven Schiff.

Also present: Cherri L. Branson, associate counsel; Martine M. DiCroce, clerk; and Martha B. Morgan, minority professional staff, Committee on Government Operations.

OPENING STATEMENT OF CHAIRMAN TOWNS

Mr. TOWNS. We will now move into the hearing. It is my understanding that Dr. McAfee must get to Dulles. In addition, I want to ask the members of the subcommittee to refrain from asking questions here because we are trying to get him through his entire testimony in time for him to make a flight. We are going to deviate from the normal pattern.

I understand protocol, but at this time I would like to ask for an exception and ask the Members to wait until after Dr. McAfee testifies. Thank you very much for your cooperation. Dr. McAfee, your entire statement will be included in the record. If you could just summarize within 5 minutes, we would greatly appreciate it.

[The prepared statement of Mr. Towns follows:]

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ONE HUNDRED THIRD CONGRESS
Congress of the United States
House of Representatives

Human Resources and Intergovernmental Relations
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OPENING STATEMENT OF
CHAIRMAN ED TOWNS
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS
"DOMESTIC VIOLENCE AS A PUBLIC HEALTH ISSUE"

OCTOBER 5, 1994

THANK YOU FOR ATTENDING THE SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS HEARING ON "DOMESTIC VIOLENCE AS A PUBLIC HEALTH ISSUE".

THE HEARING WILL EXAMINE THE FEDERAL RESPONSE TO DOMESTIC VIOLENCE, THE VIEW OF INTERSPOUSAL AND INTRA-PARTNER VIOLENCE AS A PUBLIC HEALTH ISSUE, THE MENTAL HEALTH, PHYSICAL WELL-BEING AND FINANCIAL COSTS OF DOMESTIC VIOLENCE AND POTENTIAL PREVENTATIVE ACTIONS WITHIN AND OUTSIDE OF THE FEDERAL GOVERNMENT.

UNTIL RECENTLY, DOMESTIC VIOLENCE HAS BEEN VIEWED PRIMARILY AND PREDOMINANTLY AS A CRIMINAL JUSTICE ISSUE. THEREFORE, PROponents FOR A SOLUTION TO THE DOMESTIC VIOLENCE PROBLEM URGED STATE LEGISLATURES TO PASS LAWS WHICH ALLOWED THE ABUSED SPOUSE TO OBTAIN TEMPORARY RESTRAINING AND PROTECTIVE ORDERS; REQUIRED LOCAL POLICE AUTHORITIES TO ARREST OR OTHERWISE REMOVE AN ABUSIVE SPOUSE FROM THE HOME AND FUND SHELTERS FOR BATTERED WOMEN. HOWEVER THOSE MEASURES DID NOT DECREASE THE INCIDENCE OR SEVERITY OF DOMESTIC VIOLENCE.

TODAY, DOMESTIC VIOLENCE IS THE LEADING CAUSE OF DEATH AND INJURY TO WOMEN BETWEEN THE AGES OF 15 AND 44. MOST STUDIES SUGGEST THAT BETWEEN 2 MILLION AND 4 MILLION WOMEN ARE PHYSICALLY BATTERED EACH YEAR BY PARTNERS INCLUDING HUSBANDS, FORMER HUSBANDS AND INTIMATE PARTNERS. OVER ONE MILLION WOMEN, ACCOUNTING FOR 20-30% OF ALL HOSPITAL EMERGENCY ROOM VISITS BY INJURED WOMEN ARE THE RESULT OF DOMESTIC VIOLENCE. THE FBI ESTIMATES THAT 30% OF WOMEN WHO WERE MURDERED IN 1990 WERE KILLED BY HUSBANDS OR BOYFRIENDS.

ADDITIONALLY, DOMESTIC VIOLENCE HAS A SERIOUS MENTAL HEALTH COMPONENT. THE MOST COMMON DIAGNOSIS IS DEPRESSION.

AND DOMESTIC VIOLENCE IS A MAJOR PREDICATE FOR SUICIDE

ATTEMPTS AND SUBSTANCE ABUSE AMONG WOMEN. TWENTY-FIVE PERCENT OF FEMALE SUICIDES ARE BATTERED WOMEN AND 25 PERCENT OF WOMEN SEEKING EMERGENCY PSYCHIATRIC SERVICES HAVE BEEN ASSAULTED BY A CURRENT OR FORMER SPOUSE, OR INTIMATE PARTNER.

FINALLY, DOMESTIC VIOLENCE HAS SOCIETAL COSTS OUTSIDE OF THE FAMILY. THE AMA HAS ESTIMATED THAT THE COSTS OF TREATING DOMESTIC VIOLENCE RANGES BETWEEN \$2 AND \$5.3 BILLION IN DIRECT MEDICAL COSTS TO HEALTH CARE ANNUALLY. ACCORDING TO THE BUREAU OF NATIONAL AFFAIRS, DOMESTIC VIOLENCE COSTS BUSINESS \$3-5 BILLION ANNUALLY IN LOSS OF PRODUCTIVITY DUE TO ABSENTEEISM, EMPLOYEE TURNOVER AND HEALTH-CARE EXPENSES.

VIEWING DOMESTIC VIOLENCE AS A PUBLIC HEALTH ISSUE IS NOT AN ISSUE OF RE-DEFINING OR RE-EXAMINING THE CAUSES OR CONSEQUENCES OF VIOLENCE. INSTEAD, THE CONCEPT OF DOMESTIC VIOLENCE AS A PUBLIC HEALTH ISSUE INVOLVES THE USE OF PUBLIC HEALTH APPROACHES TO ADDRESS THE PROBLEM OF DOMESTIC VIOLENCE. IN ESSENCE PUBLIC HEALTH APPROACHES FOCUS ON PREVENTION, EDUCATION, GOAL-ORIENTED PRACTICES AND MOBILIZING EXISTING INTERDISCIPLINARY RESOURCES TO REDUCE OCCURRENCE.

CLEARLY, DOMESTIC VIOLENCE IS A MULTI-LAYERED PROBLEM WHICH MAY REQUIRE SEVERAL DIFFERENT TYPES OF SOLUTIONS. HOWEVER, THE MOST IMPORTANT STEP IN THE PROCESS OF ELIMINATING VIOLENCE AGAINST WOMEN MAY SIMPLY BE PUBLIC AWARENESS. LAST YEAR, HOUSE JOINT RESOLUTION 178, WHICH WOULD HAVE DECLARED OCTOBER 1994 AS DOMESTIC VIOLENCE AWARENESS MONTH WAS INTRODUCED. THE MEASURE WAS PASSED BY THE HOUSE OF REPRESENTATIVES ON OCTOBER 26, 1993. THE BILL WAS REFERRED TO THE JUDICIARY COMMITTEE OF THE SENATE. IT IS STILL THERE.

STATEMENT OF ROBERT E. McAFEE, PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Dr. McAFEE. Thank you very much, Mr. Chairman. I thank Congressman Wyden and others who I hopefully have not inconvenienced with this. The reason I asked for this exception is that I do have an assignment to speak on domestic violence tonight before a rather large group of people at 8. It happens to be 5,000 miles from here, and that is what makes my travel important.

Mr. TOWNS. And Dulles Airport is so far away.

Dr. McAFEE. It seems that way, doesn't it.

Mr. Chairman and members of the subcommittee, I am Bob McAfee. I am a practicing general surgeon in Portland, ME, and I am president of the American Medical Association.

On behalf of the AMA, I am very pleased to have this opportunity to testify regarding the very serious issue of domestic violence. We commend the subcommittee for holding this hearing and delving into the subject of domestic violence. Violence in general is totally unacceptable, but particularly insidious and troubling is domestic violence in our society today.

The prevalence of such violence is an absolute national disgrace. Violence is the leading cause of injuries to women. Each 12 seconds, 24 hours a day, 365 days a year, a woman is punched or kicked or slapped or worse in this country. An estimated 2 to 4 million women are battered each year by their partners. Thirty-five percent of women who seek emergency treatment in emergency wards are victims of violence.

An estimated 12 rapes occur every hour. Up to 30 percent of obstetric patients are physically abused while pregnant, and 50 percent of women murdered in the United States are killed by their partners, those who theoretically should love them the most. Women who are victims of abuse are more likely to abuse their children, and these sobering statistics clearly demonstrate that domestic violence in the United States is a major medical and public health problem.

I will never forget the day that I met a cardiologist who started a hospital-based treatment center in Kenosha, WI, for abused women. When I met him, I said, "Kevin, I understand you are a cardiologist." He said, "yes." I said, "but I also understand that you treat battered women." He said, "yes, and so do you." And that is a message I have carried to every medical audience across this country: that if you treat adult patients, you have had in your office within the last 2 weeks at least one victim of domestic violence, and unless you begin to screen and ask, you will not know who that is.

The AMA and physicians have been and continue to be very active in efforts to address problems of domestic and family violence. In the past several years, we have undertaken a substantial number of activities in the area of family violence control and prevention.

For example, the AMA has published and widely distributed its diagnostic and treatment guidelines on child physical abuse, child sexual abuse, domestic violence, and elderly abuse. Also, we believe that our strong voice in support of the Violence Against Women Act

assisted significantly in its inclusion in the crime bill signed by the President last month.

As the president of the AMA, I take pride in the fact that we have organized a National Coalition of Physicians Against Violence, now numbering in excess of 7,000 physicians. Also, on March 11th through the 13th of this year, we cosponsored a National Conference on Family Violence, along with the American Bar Association entitled, "Health and Justice in Family Violence," in Washington, DC, which focused on how medicine and the law can work effectively together to address family violence.

We have presented testimony many times before the Congress on the subject of domestic and family violence. We are on the front lines, Mr. Chairman, trying to reverse this epidemic. With a problem as prevalent as domestic violence, the AMA guidelines recommend routine screening in the primary care setting.

Physicians must be on the lookout and must use their position of trusted caregivers to help their patients who are victimized by violence. Our research indicates that 80 percent of Americans feel that they could confide in a physician if they had been either a victim or a perpetrator of family violence. That is slightly more than wish to tell their priest, their pastor or their rabbi, and certainly it is considerably more than wish to tell the police.

Patients clearly trust their physicians, and we must continue to justify that trust. Routine screening of all women patients should take place in all settings where care is rendered—surgical, primary care, pediatric, prenatal particularly, and mental health settings, as well as emergency departments, because some women may not initially recognize themselves as battered.

The physician should routinely ask all women direct specific questions about abuse. The medical encounter may provide the only opportunity to stop the cycle of violence before more serious injuries occur, and intervention begins by gathering information. Providing the woman with a different kind of experience, one in which she is respected and taken seriously, one that lets her know she doesn't deserve to be abused, one that offers the possibility of support and safety and one that encourages her own choices and decisionmaking, is in itself therapeutic and an important step.

In situations where domestic violence is occurring, it is imperative that the physician inquire about a battered woman's safety before she leaves the medical setting. The severity of current or past injury is not an accurate predictor of future violence. Many women minimize the danger that they face. After assessing the situation, plans for the woman's safety should be discussed before she leaves the physician's office.

Various options should be considered. Does she have friends and family with whom she can stay, does she want immediate access to a shelter? If none is available, can she be admitted to the hospital? Does she need referrals to local domestic violence organizations? If the patient feels it is safe to do so, she should be provided with written information, including phone numbers on legal options, local counseling and crisis intervention services, shelters and community resources.

In addition, educational materials on domestic violence in waiting areas and examination rooms may help patients identify such violence as a personal health problem.

In conclusion, Mr. Chairman, the AMA is strongly concerned about the domestic and family violence so prevalent in our society today, and about the impact it exerts on our health care system. The issue of family violence has direct relevance to all practicing physicians. It is the practicing physician who must treat the results of such violence.

We have worked hard to bring about changes for the better, and we will continue to do so. Striving to effect a curbing of family violence is a major goal of the American Medical Association. This past June, characterizing family violence as a "centerpiece public health issue," our House of Delegates resolved to continue its leadership role in bringing physicians and other professionals and their organizations into collaborative efforts to prevent and reduce family violence in our society.

Finally, I would like to conclude with a special appeal to all women perhaps hearing television or radio accounts or reading newspaper articles about this hearing, Mr. Chairman: "If violence is a part of your life, talk to your doctors. They will listen. They do care. They want to help, and they are ready to help."

I thank you very much, Mr. Chairman, for the opportunity to appear today, and particularly your kindness in accommodating my schedule.

[The prepared statement of Mr. McAfee follows:]

American Medical Association

Physicians dedicated to the health of America



515 North State Street
Chicago, Illinois 60610

Statement

to the

Subcommittee on Human Resources and
Intergovernmental Relations
House Committee on Government Operations

U.S. House of Representatives

RE: DOMESTIC VIOLENCE

Presented by: Robert E. McAfee, MD

October 5, 1994

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Human Resources and Intergovernmental Relations Subcommittee
of the
House Committee on Government Operations
Presented by
Robert E. McAfee, MD
RE: Domestic Violence
October 5, 1994

Mr. Chairman and Members of the Committee:

My name is Robert E. McAfee, MD. I am a practicing general surgeon in Portland, Maine, and President of the American Medical Association (AMA). Accompanying me today is Jeffery M. Stokols, JD, senior legislative counsel with the AMA's Division of Federal Legislation. On behalf of the AMA, I am pleased to have this opportunity to testify regarding the very serious issue of domestic violence. As physicians, we are deeply distressed by the volume of care that we provide as a direct result of violence in this country, including domestic violence.

Introduction

We commend the Committee for holding this hearing and delving into the subject of domestic violence. It is particularly noteworthy that the hearing is being held in October, at the one year anniversary of Domestic Violence Awareness Month. However, regardless of the particular month, physicians are witnesses to the fact that for its victims, domestic violence is not merely a month-long recognition -- it is a daily, a weekly, and all too often a lifelong struggle.

Violence in this country today, in all of its forms, has indisputably become a major medical and public health epidemic. America today is a land of violence. Violence absolutely surrounds us in our society; we cannot run or hide from it, we cannot escape it. The severe, broad-reaching negative impact of violence on the health of individual Americans, their families and the nation results in a huge and ever-growing number of encounters with the health care system. Care for the victims of violence strains the health care system and adds significantly and unnecessarily to the U.S. health care bill. This avoidable care is growing in prominence as a source of our nation's health care expenditures. It has been reported that over 500,000 emergency department visits annually are due to violence-related injury and that two-thirds of crime victims treated in hospitals are uninsured. It has been estimated that the direct medical costs of all violence-related injuries add more than \$5.3 billion to U.S. health expenditures.

Violence in general is totally unacceptable, but particularly insidious and troubling is domestic violence in our society today. The prevalence of such violence is an absolute national disgrace. Violence is the leading cause of injuries in women. Every 12 seconds, 24 hours a day, 365 days a year, a woman is punched, kicked, slapped -- or worse -- in this country. An estimated 2-4 million women are battered each year by their partners. 35% of women who seek emergency department treatment are the victims of violence. An estimated 12 rapes occur every hour. 37% of obstetric patients are physically abused while pregnant. 50% of women murdered in the U.S. are killed by their partners. Women who are victims of abuse are more likely to abuse their children. These sobering statistics clearly demonstrate that domestic violence in the U.S. is a major medical and public health issue.

Past AMA Actions

The AMA and physicians have been, and continue to be, very active in efforts to address problems of domestic and family violence. In the past several years, we have undertaken a substantial number of activities in the area of family violence control and prevention. These activities are described in the attached 1993 Report of the AMA Board of Trustees. This report is a follow-up to the attached 1991 AMA Council on Scientific Affairs report that addresses violence against women and that initiated a broad-based AMA campaign to alert and educate the health care community to the widespread prevalence of violence against women. Physicians see the results of violence far too often, and we are sensitive to the needs of these victims of violence. To break what must be viewed as a cycle of violence, physicians are committed to help the victims of violence take steps to prevent repeat victimization.

As part of our campaign against family violence, the AMA has published and widely distributed its Diagnostic and Treatment Guidelines on child physical abuse, child sexual abuse, domestic violence, and elder abuse. Additionally, on November 12 of last year, we testified before the United States Senate Judiciary Committee on the "Violence Against Women Act," at which time we expressed the extreme concern of the physician community over the detestable problem of violence against women in our society and supported the bill. In May of this year, in a letter to Senate and House crime bill conferees, we reiterated our support for the provisions of this Act. We believe that our strong voice in support of the "Violence Against Women Act" contributed significantly in the inclusion of its provisions in the crime bill signed by the President last month.

Physical and sexual violence against women is at epidemic proportions, the social and economic costs to society are staggering, and we must take definite steps to get this major problem under control

before more innocent people are victimized. The AMA believes that, until the problem is confronted and solved, the nation's conscience must be continually reminded of the prevalence and severity of domestic violence and of our individual and collective responsibility to stop this epidemic. The AMA pledges to continue its active role in confronting the problem and educating our physicians and the public.

As the President of the AMA, I take pride in the fact that we have organized a national coalition of physicians against violence. Also, on March 11-13 of this year, we sponsored the *National Conference on Family Violence: Health and Justice* in Washington, D.C., which focused on how medicine and the law can work effectively together to address family violence. We have presented testimony many times before the Congress on the subject of domestic and family violence, most recently before the Senate Special Committee on Aging this past June. We are on the front lines trying to reverse this epidemic.

AMA Diagnostic and Treatment Guidelines on Domestic Violence

As I mentioned earlier, the AMA has published and widely distributed its Diagnostic and Treatment Guidelines on domestic violence to members of our coalition against violence and to state medical societies (also attached). These protocols are designed expressly for frontline physicians--those of us who must sew up, or clean up, or bind up--the injuries that too often are the results of domestic violence. Unless we take steps beyond just the medical treatment of such violence, there is a significant risk that it will escalate.

With a problem as prevalent as domestic violence, the AMA Guidelines recommend routine screening in the primary care setting. Physicians must be on the lookout, and must use their position as trusted caregivers to help their patients who are victimized by violence. Our research indicates that 80

percent of Americans feel that they could confide in a physician if they had been either a victim or a perpetrator of family violence. Clearly, patients trust their physicians, and we must continue to justify that trust.

Routine screening of all women patients should take place in all settings where care is rendered--surgical, primary care, pediatric, prenatal, and mental health settings--as well as emergency departments. Because some women may not initially recognize themselves as "battered," the physician should routinely ask all women direct, specific questions about abuse. Such questions may be included in the social history, past medical history, review of systems, or history of present illness, as appropriate.

Although women may not bring up the subject of abuse on their own, many will discuss it when asked simple, direct questions in a nonjudgmental way and in a confidential setting. The patient should be interviewed alone, without her partner present. The physician should make an opening supportive statement, such as: "Because abuse and violence are so common in women's lives, I've begun to ask my patients about it routinely." Even if the patient does not respond at the time, the fact that a physician, a caregiver, is concerned and believes that battering is a possibility will make an impression. The physician's concern about abuse validates her feelings and reinforces her capacity to seek help when she feels ready and able to do so.

Routine questions about violence not only identify women who are currently being abused but also serve to assess the safety of women who have been battered in the past. Such screening also heightens the awareness of those who have not been in abusive relationships and could have a preventive effect. Routine assessment is particularly important for women who have left a violent relationship; leaving

an abusive partner or finalizing a divorce may increase her risk for abuse. The physician should provide appropriate follow-up during legal proceedings, and even assess the woman's need for emergency shelter or other resources.

A medical encounter may provide the only opportunity to stop the cycle of violence before more serious injuries occur, and intervention begins by gathering information. Providing the woman with a different kind of experience -- one in which she is respected and taken seriously; one that lets her know she doesn't deserve to be abused; one that offers the possibility of support and safety; and one that encourages her own choices and decision-making -- is, in itself, therapeutic and an important step. Questions about domestic violence should be asked in the physician's own words and in a nonjudgmental way. Here are some examples of recommended questions:

- Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
- Are you (have you ever been) in a relationship in which you felt you were treated badly? In what ways?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has your partner ever forced you to have sex when you didn't want to? Does he ever force you to engage in sex that makes you feel uncomfortable?
- We all fight at home. What happens when you and your partner fight or disagree?
- Do you ever feel afraid of your partner?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- You mentioned that your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
- Do you have guns in your home? Has your partner ever threatened to use them when he is angry?

Once abuse is recognized, a number of interventions are possible, but even if a woman is not ready to leave the relationship or take other action, the physician's recognition and validation of her situation is important. Silence, disregard, or disinterest convey tacit approval or acceptance of domestic violence. In contrast, recognition, acknowledgement, and concern confirm the seriousness of the problem and the need to solve it. Optimal care for the woman in an abusive relationship also depends on the physician's working knowledge of community resources that can provide safety, advocacy, and support.

The injury or complaint that precipitated the health care encounter requires evaluation and appropriate treatment. In addition, the physician should ask about the patient's use of pain, sleeping, or antianxiety medications. Psychiatric problems, including severe depression, panic disorder, suicidal tendencies or substance abuse, may hinder the battered woman's ability to assess her situation or take appropriate action. When serious psychiatric conditions are present, an appropriate treatment plan includes psychiatric evaluation and treatment. On the other hand, emotional, behavioral, and cognitive symptoms of abuse can be misinterpreted as psychiatric in origin. Physicians must make sure that the mental health professional to whom they refer the patient is sensitive to these issues.

Alcohol or drugs may be used to rationalize violent behavior. Perpetrators and family members may insist that substance abuse is the problem. Evidence indicates that while substance abuse and violent behavior frequently coexist, the violent behavior will not end unless interventions address the violence as well as the addiction. Similarly, mental illness is rarely the cause of domestic violence, although mental illness in a batterer can lead to loss of control and increased frequency and severity of violence. Treating the mental illness alone will not end the violence. Both issues must be addressed.

Couples' counseling or family intervention, on the other hand, is generally contraindicated in the presence of domestic violence. Attempts to implement family therapy in the presence of ongoing violence may actually increase the risk of serious harm. The first concern must be for the safety of the woman and her children.

Women are not the only victims at home; child abuse has been reported to occur in 33% to 54% of families where adult domestic violence occurs. In situations when children are also being abused, coordinated liaisons between advocates for victims of domestic violence and child protective service agents should be used to insure the safety of both the mother and her children. Otherwise, the reporting and investigation of alleged child abuse may increase the mother's risk of abuse.

It is imperative that the physician inquire about a battered woman's safety before she leaves the medical setting. The severity of current or past injury is not an accurate predictor of future violence, and many women minimize the danger they face. After assessing the situation, plans for the woman's safety should be discussed before she leaves the physician's office. Various options should be considered:

- Does she have friends and family with whom she can stay?
- Does she want immediate access to a shelter?
 - If none is available, can she be admitted to the hospital?
 - If she doesn't need immediate access to a shelter, give her written information about shelters and other resources if it is safe to do so.
- Does she need immediate medical or psychiatric intervention?
- Does she want immediate access to counseling to help her deal with the stress caused by the abuse?
- Does she want to return to her partner, with a follow-up appointment at a later date?

- Does she need referrals to local domestic violence organizations?

If the patient feels it is safe to do so, she should be provided with written information (including phone numbers) on legal options, local counseling and crisis intervention services, shelters, and community resources. In addition, educational materials on domestic violence in waiting areas and examination rooms may help patients identify violence as a personal health problem.

Physician awareness is growing. In addition to information from the AMA, national organizations on domestic violence and many local and state battered women's programs have information available for use in physician offices. The National Domestic Violence hotline (800-333-SAFE) is a 24-hour resource to help women find local shelters. Counselors speak Spanish as well as English. The National Woman Abuse Prevention Center (202-857-0216) publishes fact sheets on domestic violence, a quarterly newsletter, and a series of brochures. Some of the material is translated into Spanish and Polish. The American College of Obstetricians and Gynecologists (202-836-2518) publishes "The Abused Woman," a publication for patients. The Family Violence Prevention Fund (415-821-4553) provides direct services to victims and develops public policy and training programs.

Local domestic violence shelters and statewide domestic violence programs are frequently listed in the phone book. They can help with housing, information about legal rights, welfare applications, and counseling (including peer groups and counseling for children). They may have brochures for distribution to women patients that address issues and list local resources. Many programs offer these services without charge.

To summarize, in order for a physician to do his or her share to appropriately recognize and treat victims of domestic violence, he or she must be vigilant to keep the professional "RADAR" turned on:

- Remember to screen patients about violence.
- Ask patients questions such as: "At any time, has a partner hit, kicked or otherwise hurt or frightened you?"
- Document findings. Information in the patient's chart about "suspected domestic violence" can serve a valuable function in court should the patient seek legal action. A physician's documentation validates the victim's allegations.
- Assess the patient's safety. Is it safe to go home? Find out if any weapons are kept in the house, if the children are in danger and if violence is escalating.
- Review options with the patient. Know about referral options.

Conclusion

On a personal note, I will never forget the day I met a cardiologist who started a hospital-based treatment center in Kenosha, Wisconsin for abused women.

"I understand you treat battered women," I said as we were introduced.

He replied, "And so do you."

My education began at that instant.

What he meant, of course, was that when physicians examine patients with cuts and bruises and broken arms, we may actually be treating victims of abuse.

In conclusion, the AMA is strongly concerned about the domestic and family violence so prevalent in our society today and about the impact it exerts on our health care system. The issue of family violence has direct relevance to all practicing physicians. It is the practicing physician who must treat the results of such violence. We have worked hard to bring about changes for the better, and we will continue to do so. Striving to effect a curbing of family violence is a major goal of the AMA. This

past June, characterizing family violence as a "centerpiece public health issue", our House of Delegates resolved to "continue its leadership role in bringing physicians and other professionals and their organizations into collaborative efforts to prevent and reduce family violence in our society."

Finally, I would like to conclude with a special appeal to all women hearing TV or radio accounts or reading newspaper articles about this hearing: If violence is a part of your life, talk to your doctors. They will listen. They do care. They want to help. They are ready to help.

Thank you for affording me the opportunity to appear here today. I will be pleased to respond to any questions you may have.

American Medical Association

Physicians dedicated to the health of America



Diagnostic and Treatment Guidelines
on

Domestic Violence



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These guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. These guidelines reflect the views of scientific experts and reports in the scientific literature as of March 1992.

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Introduction

Physical and sexual violence against women is a public health problem that has reached epidemic proportions. An estimated 8-12 million women in the United States are at risk of being abused by their current or former intimate partners. This violence causes serious physical, psychological, and social sequelae for these women and their families.

Domestic violence, also known as partner-abuse, spouse-abuse, or battering, is one facet of the larger problem of family violence. Family violence occurs among persons within family or other intimate relationships, and includes child abuse and elder abuse as well as domestic violence. Family violence usually results from the abuse of power or the domination and victimization of a physically less powerful person by a physically more powerful person.

Until the mid-1970s, assaults against wives were considered misdemeanors in most states, even when an identical assault against a stranger would have been considered a felony. The current consensus among state and federal policy makers is:

- Domestic violence is a crime
- Safety for victims of domestic violence and their children must be a priority
- Changes in traditional services, including medical care, are needed to meet the needs of abused women

Most states have improved the legal remedies available to battered women, and a number of state health departments have developed protocols for health care

providers. Since January 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has required that all accredited hospitals implement policies and procedures in their emergency departments and ambulatory care facilities for identifying, treating, and referring victims of abuse. The standards require educational programs for hospital staff in domestic violence, as well as elder abuse, child abuse, and sexual assault.

Because a physician may be the first nonfamily member to whom an abused woman turns for help, he or she has a unique opportunity and responsibility to intervene. Battered women often present with repeated injuries, medical complaints, and mental health problems, all of which result from living in an abusive relationship. Physicians in all practice settings routinely see the consequences of violence and abuse, but often fail to acknowledge their violent etiologies. By recognizing and treating the effects of domestic violence, and by providing referrals for shelter, counseling and advocacy, physicians can help battered women regain control of their lives.

These guidelines are intended to:

- Familiarize you with the magnitude of the problem
- Describe how to identify abuse and violence through routine screening and recognition of clinical presentations
- Help you assess the impact of abuse and violence on your patients' health and well-being

- Provide examples of how to ask questions in ways that can elicit meaningful responses and help women to explore their options and take action
- Provide information on appropriate resources for referral and address frequently encountered obstacles
- Familiarize you with the legal aspects of medical care, including reporting requirements

Facts About Domestic Violence

Domestic violence is characterized as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation. These behaviors are perpetrated by someone who is or was involved in an intimate relationship with the victim. Although some women are successful in escaping a violent relationship after the first assault, most abuse is recurrent and escalates in both frequency and severity. In addition, a woman's independence may be compromised by her partner's need to dominate her and control many aspects of her life: He may restrict her access to food, clothing, money, friends, transportation, health care, social services or employment.

Research has failed to demonstrate a psychological or cultural profile of battered women. However, certain groups of women appear to be at somewhat higher risk for abuse: women who are single, separated, or divorced (or are planning a separation or divorce); women between the ages of 17 and 28; women who abuse alcohol or other drugs—or whose partners do; women who are pregnant; or women whose partners are excessively jealous or possessive. Children raised in violent homes may be at increased risk for perpetrating or experiencing violence in adulthood, but not all abusive partners or abused women were exposed to family violence while growing up.

Domestic violence cuts across all racial, ethnic, religious, educational, and socioeconomic lines. However, physicians should be aware that a woman's family background, as well as her cultural and religious beliefs may influence her perceptions of abuse.

In addition, her socioeconomic status influences her access to medical care. Women of higher socioeconomic status are more likely to seek care in private practice settings, while low-income women are more likely to go to clinics and emergency departments.

Conservative studies indicate that two million women per year are assaulted by their partners, but experts believe that the true incidence of partner violence is probably closer to four million cases per year.

- Nearly one quarter of women in the United States—more than 12 million—will be abused by a current or former partner some time during their lives.
- 47% of husbands who beat their wives do so three or more times a year.
- According to FBI statistics, 30% of women who were murdered in 1990 were killed by husbands or boy-friends. It is estimated that 52% of female murder victims were killed by a current or former partner.
- 14% of ever-married women report being raped by their current or former husbands, and rape is a significant or major form of abuse in 54% of violent marriages.

Clinical studies underscore the prevalence of domestic violence and its relationship to continued or repeated trauma and consequent medical and psychiatric problems. More than half of all nonfatal assaults result in injury, and 10% of the victims require hospitalization or emergency medical treatment. Seventy-five percent of battered women

first identified in a medical setting will go on to suffer repeated abuse. According to various studies, battered women may account for:

- 22% to 35% of women seeking care for any reason in emergency departments, the majority of whom are seen by medical or other nontrauma services
- 19% to 30% of injured women seen in emergency departments
- 14% of women seen in ambulatory-care internal medicine clinics (28% have been battered at some time)
- 25% of women who attempt suicide
- 25% of women utilizing a psychiatric emergency service
- 23% of pregnant women seeking prenatal care
- 45% to 59% of mothers of abused children
- 58% of women over 30 years old who have been raped

Most research has focused on women who have been battered by male partners, and, in fact, women are more likely than men to be seriously injured by their partners. However, the terms spouse-abuse and partner-abuse reflect an awareness that men also can be abused in intimate relationships. The extent to which findings about battered women can be applied to men who are abused by women, or to the under-recognized problem of violence within gay and lesbian relationships, is not known. In clinical practice, these issues also must be addressed in a sensitive and nonjudgmental manner.

Forms of Abuse

Domestic violence is an ongoing, debilitating experience of physical, psychological and/or sexual abuse in the home, associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. Whenever a woman is placed in physical danger or controlled by the threat or use of physical force, she has been abused. The risk for abuse is greatest when a woman is separated from supportive networks.

Physical abuse is usually recurrent and escalates in both frequency and severity. It may include the following:

- Pushing, shoving, slapping, punching, kicking, choking
- Assault with a weapon
- Holding, tying down, or restraining her
- Leaving her in a dangerous place
- Refusing to help when she is sick or injured

Emotional or psychological abuse may precede or accompany physical violence as a means of controlling through fear and degradation. It may include the following:

- Threats of harm
- Physical and social isolation
- Extreme jealousy and possessiveness
- Deprivation

- Intimidation
- Degradation and humiliation
- Calling her names and constantly criticizing, insulting and belittling her
- False accusations, blaming her for everything
- Ignoring, dismissing, or ridiculing her needs
- Lying, breaking promises, destroying trust
- Driving fast and recklessly to frighten and intimidate her

Sexual abuse in violent relationships is often the most difficult aspect of abuse for women to discuss. It may include any form of forced sex or sexual degradation, such as:

- Trying to make her perform sexual acts against her will
- Pursuing sexual activity when she is not fully conscious or is not asked or is afraid to say no
- Hurting her physically during sex or assaulting her genitals, including use of objects or weapons intravaginally, orally, or anally
- Coercing her to have sex without protection against pregnancy or sexually transmissible diseases
- Criticizing her and calling her sexually degrading names

Interviewing Process

Domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify *routine screening* of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. Because some women may not initially recognize themselves as “battered,” the physician should routinely ask all women direct, specific questions about abuse. Such questions may be included in the social history, past medical history, review of systems, or history of present illness, as appropriate.

Although women may not bring up the subject of abuse on their own, many will discuss it when asked simple, direct questions in a nonjudgmental way and in a confidential setting. The patient should be interviewed *alone*, without her partner present. The physician should make an opening supportive statement, such as: “Because abuse and violence are so common in women’s lives, I’ve begun to ask about it routinely.” Even if the patient does not respond at the time, the fact that a provider is concerned and believes that battering is a possibility will make an impression. The physician’s concern about abuse validates her feelings and reinforces her capacity to seek help when she feels ready and able to do so.

Routine questions about violence not only identify women who are currently being abused but also serve to assess the safety of women who have been battered in the past and to heighten the awareness of those who have not been in abusive relationships. Routine assessment is particularly important for women who have left a violent relationship; leaving an abusive partner or finalizing a divorce

may increase her risk for abuse. The physician should provide appropriate follow-up during legal proceedings, and assess the woman’s need for emergency shelter or other resources.

A medical encounter may provide the only opportunity to stop the cycle of violence before more serious injuries occur, and intervention begins by gathering information. Providing the woman with a different kind of experience—one in which she is respected and taken seriously; one that lets her know she doesn’t deserve to be abused; one that offers the possibility of support and safety, and one that encourages her own choices and decision-making is, in itself, therapeutic and an important step. Questions about domestic violence should be asked in the physician’s own words and in a nonjudgmental way. Here are some examples of recommended questions:

- Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
- Are you (have you ever been) in a relationship in which you felt you were treated badly? In what ways?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has your partner ever forced you to have sex when you didn’t want to? Does he ever force you to engage in sex that makes you feel uncomfortable?
- We all fight at home. What happens when you and your partner fight or disagree?

- Do you ever feel afraid of your partner?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- You mentioned that your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
- Do you have guns in your home? Has your partner ever threatened to use them when he was angry?

Diagnosis and Clinical Findings

Injury: Episodes of physical assault characterize abusive relationships. Physicians should especially consider the possibility of assault when the woman's explanation of how an injury occurred does not seem plausible or when there has been a delay in seeking medical care. Common types of injury include:

- Contusions, abrasions, and minor lacerations, as well as fractures or sprains
- Injuries to the head, neck, chest, breasts, and abdomen
- Injuries during pregnancy
- Multiple sites of injury
- Repeated or chronic injuries

Medical findings: The stress of living in an ongoing abusive relationship may cause any of the following:

- Chronic pain, psychogenic pain, or pain due to diffuse trauma without visible evidence
- Physical symptoms related to stress, chronic post-traumatic stress disorder, other anxiety disorders, or depression. Examples are:
 - Sleep and appetite disturbances
 - Fatigue, decreased concentration, sexual dysfunction
 - Chronic headaches
 - Abdominal and gastrointestinal complaints
 - Palpitations, dizziness, paresthesias, dyspnea
 - Atypical chest pain
- Gynecologic problems, frequent vaginal and urinary tract infections, dyspareunia, pelvic pain
- Frequent use of prescribed minor tranquilizers or pain medications

- Frequent visits with vague complaints or symptoms without evidence of physiologic abnormality

Many practitioners have noted that chronic illnesses such as asthma, seizure disorders, diabetes, arthritis, hypertension, and heart disease may be exacerbated or poorly controlled in women who are being abused.

Sexual coercion and assault are common expressions of domestic violence. Assessment for sexual abuse and rape should be addressed in the sexual or social history taken during routine primary care visits, in discussions of birth control and safer sexual practices and in evaluations during gynecologic and obstetric visits.

Pregnancy: Because of the risk to the mother and fetus, assessment for abuse should be incorporated into routine prenatal and postpartum care. Presentations include:

- Injuries, particularly to the breasts, abdomen, and genital area, or unexplained pain.
- Substance abuse, poor nutrition, depression, and late or sporadic access to prenatal care
- "Spontaneous" abortions, miscarriages, and premature labor

Mental Health/Psychiatric Symptoms: Assessment for domestic violence should be included as a routine part of psychiatric intakes and evaluations. The stress of domestic violence may aggravate comorbid psychiatric disorders. Psychiatric symptoms of abuse include the following:

- Feelings of isolation and inability to cope

- Suicide attempts or gestures
- Depression
- Panic attacks and other anxiety symptoms
- Alcohol or drug abuse
- Post-traumatic stress reactions and/or disorder

Routine assessment of domestic violence in the patient's family is important for both men and women in alcohol and drug rehabilitation programs. Nearly 75% of all wives of alcoholics have been threatened, and 45% have been assaulted by their addicted partners.

Control in a Relationship: An abusive partner's use of control within a violent relationship may result in:

- Limited access to routine and/or emergency medical care
- Noncompliance with treatment regimens
- Not being allowed to obtain or take medication
- Missed appointments
- Lack of independent transportation, access to finances, ability to communicate by phone
- Failure to use condoms or other contraceptive methods
- Not being told by a partner that he is infected with HIV or other sexually transmissible diseases

Behavioral Signs: Battered women exhibit a variety of responses to the stress of ongoing abuse; such patients may appear frightened, ashamed, evasive or embarrassed. A battered woman may believe she deserves the abuse because the abuser tells her so, and she may take responsibility for his violence to

maintain some sense of control over her situation. Other findings may include the following:

- Partner accompanies patient, insists on staying close, and answers all questions directed to her
- Reluctance of a patient to speak or disagree in front of her partner
- Intense irrational jealousy or possessiveness expressed by partner or reported by patient
- Denial or minimization of violence by partner or by patient
- Exaggerated sense of personal responsibility for the relationship, including self-blame for her partner's violence

Interventions

Important Considerations

Once abuse is recognized, a number of interventions are possible, but even if a woman is not ready to leave the relationship or take other action, the physician's recognition and validation of her situation is important. Silence, disregard, or disinterest convey tacit approval or acceptance of domestic violence. In contrast, recognition, acknowledgment, and concern confirm the seriousness of the problem and the need to solve it.

Optimal care for the woman in an abusive relationship also depends on the physician's working knowledge of community resources that can provide safety, advocacy, and support.

The injury or complaint that precipitated the health care encounter requires evaluation and appropriate treatment. In addition, the physician should ask about the patient's use of pain, sleeping, or antianxiety agents. Psychiatric problems, including severe depression, panic disorder, suicidal tendencies or substance abuse, may hinder the battered woman's ability to assess her situation or take appropriate action. When serious psychiatric conditions are present, an appropriate treatment plan includes psychiatric evaluation and treatment. On the other hand, emotional, behavioral, and cognitive symptoms of abuse can be misinterpreted as psychiatric in origin. Physicians must make sure that the mental health professional to whom they refer the patient is sensitive to these issues.

Alcohol or drugs may be used to rationalize violent behavior. Perpetrators and family members may insist that substance abuse is the problem. Evidence

indicates that while substance abuse and violent behavior frequently coexist, the violent behavior will not end unless interventions address the violence as well as the addiction. Similarly, mental illness is rarely the cause of domestic violence, although mental illness in a batterer can lead to loss of control and increased frequency and severity of violence. Treating the mental illness alone will not end the violence. Both issues must be addressed.

Couples' counseling or family intervention is generally contraindicated in the presence of domestic violence. Attempts to implement family therapy in the presence of ongoing violence may increase the risk of serious harm. *The first concern must be for the safety of the woman and her children.*

Often women are not the only victims at home: Child abuse has been reported to occur in 33% to 54% of families where adult domestic violence occurs. In situations when children are also being abused, coordinated liaisons between advocates for victims of domestic violence and child protective service agents should be used to insure the safety of both the mother and her children. Otherwise, the reporting and investigation of alleged child abuse may increase the mother's risk of abuse.

Patient Safety

It is imperative that the physician inquire about a battered woman's safety *before she leaves the medical setting*. The severity of current or past injury is not an accurate predictor of future violence, and many women minimize the danger they face. After assessing the situation, plans for the woman's safety should be

discussed before she leaves the physician's office. Various options should be considered:

- Does she have friends and family with whom she can stay?
- Does she want immediate access to a shelter?
 - If none is available, can she be admitted to the hospital?
 - If she doesn't need immediate access to a shelter, give her written information about shelters and other resources *if it is safe to do so*.
- Does she need immediate medical or psychiatric intervention?
- Does she want immediate access to counseling to help her deal with the stress caused by the abuse?
- Does she want to return to her partner, with a follow-up appointment at a later date?
- Does she need referrals to local domestic violence organizations?

Information and Resources

If the patient feels it is safe to do so, provide her with *written* information (including phone numbers) on legal options, local counseling and crisis intervention services, shelters, and community resources. In addition, educational materials on domestic violence in waiting areas and examination rooms may help patients identify violence as a personal health problem.

National organizations on domestic violence and many local and state battered women's programs have information available for use in physician offices. The National Domestic Violence hot line (800 333-SAFE) is a 24-hour

resource to help women find local shelters. Counselors speak Spanish as well as English. The National Woman Abuse Prevention Center (202 857-0216) publishes fact sheets on domestic violence, a quarterly newsletter, and a series of brochures. Some of the material is translated into Spanish and Polish. The American College of Obstetricians and Gynecologists (202 863-2518) publishes "The Abused Woman," a publication for patients. The Family Violence Prevention Fund (415 821-4553) provides direct services to victims and develops public policy and training programs.

Local domestic violence shelters and statewide domestic violence programs are frequently listed in the phone book. They can help with housing, information about legal rights, welfare applications, and counseling (including peer groups and counseling for children). They may have brochures for distribution to women patients that address issues and list local resources. Many programs offer these services without charge.

Barriers to Identification

Patient Barriers

Many women are reluctant or unable to seek help. Some are literally held captive and not allowed out of the house. Others may not have money or means of transportation. If they do come to a physician's office, they may have to leave before they are seen, rather than risk further abuse for "getting home late." Childhood experiences of physical or sexual abuse, or witnessing domestic violence, may make it more difficult for a battered woman to recognize a relationship as abusive and to take steps to protect herself. Cultural, ethnic or religious background may also influence a woman's response to abuse and her awareness of viable options. Other reasons for not mentioning abuse include:

- Fear that revelation will jeopardize her safety
- Shame and humiliation at the way she is being treated
- Thinking she deserved the abuse and is not deserving of help
- Feeling protective of her partner. He may be her sole source of love and affection when he is not abusive and may provide the financial support for her and her children.
- Lack of awareness that her physical symptoms are caused by the stress of living in an abusive relationship
- Belief that her injuries are not severe enough to mention

Because the experience of abuse is so degrading and humiliating, a woman may be reluctant to discuss it with someone who may not take her seriously, who may discount her experience, who may perceive her as deserving the

abuse, or blame her for staying with her abuser. She may fear that reporting the abuse will jeopardize her safety and destroy her means of support; she may stay in the relationship hoping that the situation will improve. Her partner may not always be abusive and this gives her hope that he will change.

Physician Barriers

Until recently, physicians rarely addressed issues of abuse and violence, even when the signs or symptoms were present. There are many reasons why physicians may avoid asking about abuse and why it may seem difficult to do so initially. Among these are:

- Lack of awareness of the prevalence, means of identification, or severity of the problem and lack of recognition of the social and psychological costs of abuse
- Thinking it is not a physician's place to intervene, or that the woman must have provoked the abuse
- Believing identification of abuse and referral for services is not part of the physician's role
- Not knowing how to intervene or help even if a woman is recognized as being battered
- "Blaming the patient" and feeling frustrated or angry if the woman doesn't leave her partner (She becomes the problem for being noncompliant with the physician's timetable)
- Disbelief because the alleged assailant is present and seems very concerned and pleasant
- Concern that discussing psychosocial issues will take an overwhelming amount of time
- Difficulty dealing with the feelings evoked by listening to a woman describe what has been done to her. The physician may feel helpless or inadequate if he or she can't "do something" to "fix" the situation.

Documentation

Thorough, well-documented medical records are essential for preventing further abuse. Furthermore, they provide concrete evidence of violence and abuse and may prove to be crucial to the outcome of any legal case. If the medical record and testimony at trial are in conflict, the medical record may be considered more credible. Records should be kept in a precise, professional manner and should include the following:

- Chief complaint and description of the abusive event, using the patient's own words whenever possible rather than the physician's assessment. "My husband hit me with a bat" is preferable to "Patient has been abused."
- Complete medical history
- Relevant social history
- A detailed description of the injuries, including type, number, size, location, resolution, possible causes, and explanations given. Where applicable, the location and nature of the injuries should be recorded on a body chart or drawing.
- An opinion on whether the injuries were adequately explained
- Results of all pertinent laboratory and other diagnostic procedures
- Color photographs and imaging studies, if applicable
- If the police are called, the name of the investigating officer and any actions taken

In addition to complete written records, photographs are particularly valuable as evidence. The physician should ask the patient for permission to take photographs. Imaging studies also may be useful. State laws that apply to the taking of photographs usually apply to x-rays as well.

- When possible, take photographs before medical treatment is given
- Use color film, along with a color standard
- Photograph from different angles, full body and close-up
- Hold up a coin, ruler, or other object to illustrate the size of an injury
- Include the patient's face in at least one picture
- Take at least two pictures of every major trauma area
- Mark photographs precisely as soon as possible with the patient's name, location of injury, and names of the photographer and others present

For medical records to be admissible in court the doctor should be prepared to testify:

- That the records were made during the "regular course of business" at the time of the examination or interview
- That the records were made in accordance with routinely followed procedures
- That the records have been properly stored and their access limited to professional staff

Legal Developments

Protection of Victims

Today every state has some form of legislation designed to offer protection to victims of domestic violence. Some states have placed additional duties on police, requiring them to make arrests in certain cases, accompany women to their homes to collect children and belongings, and inform them of their legal rights. However, despite the increased interest in domestic violence and the enhanced availability of legal remedies, compliance with or enforcement of the laws on the part of some physicians, police, prosecutors, government agencies, and courts is often less than ideal. *Physicians need to be aware of state laws and of the services available in their community for abuse victims.*

The legal remedies available to battered women vary from state to state and these laws are changing rapidly. Advocacy programs often can explain to women the legal options that are available, and can help them access the legal system. The most common civil action in domestic violence cases is a protective order, injunction, or restraining order, which is a court order that directs the batterer to stop abusing the victim. In some states, the court may have the authority to order a batterer to leave a shared residence, receive counseling, make support payments, pay medical bills, or take other action. Depending on the jurisdiction, police also may be required to arrest abusers who violate protective orders. *In any event, a woman's safety must be continually reassessed since a protective order does not guarantee it.*

Criminal actions against batterers may include prosecution for assault, battery, aggravated assault or battery, harassment,

intimidation, or attempted murder.

Historically, abused women often have been unable to pursue such charges against their spouses, and even today they may encounter police who are reluctant to take action, prosecutors who downgrade charges, and courts that are not receptive to such claims. Some states have adopted specific provisions that criminalize domestic abuse, but the lack of explicit laws does not necessarily mean that criminal prosecution is unavailable.

State Reporting Requirements

Few states have explicit mandatory reporting laws for domestic abuse, and it is not clear that mandatory reporting would best ensure the safety of competent adult victims or connect them with needed resources. However, virtually all states have some type of statute that requires physicians to report to law enforcement officials certain injuries that appear to have resulted from a criminal act. *Disclosure of a diagnosis of abuse to partners or any third party and reporting to authorities should be done only with the abused woman's knowledge and consent.*

In addition, in most areas, there are no government agencies to coordinate case management and put victims in contact with needed services for domestic violence. Thus, physicians need to be aware of local resources to make appropriate referrals and to advocate for expanded resources. In any case, physicians should emphasize that they will remain available to help in the future and should provide the patient with a list of available resources. The physician should document the diagnosis, the information conveyed and any pamphlets

information conveyed and any pamphlets or materials given to the patient, as well as the patient's decision on whether or not to allow the physician to take further action such as notifying the police.

Testimony

Medical evidence is not required in every judicial undertaking, such as divorce or custody hearings. If court evidence becomes necessary, a well-documented medical record may reduce the time a physician is required to spend in judicial proceedings. It may be possible to place the physician "on call" for court, so that he or she need appear only when it is time to testify.

The physician may be called to testify about the contents of the record or statements made. This function is distinct from the use of the physician as an expert. The physician may be

requested to give expert medical testimony and perhaps to give an opinion on whether the explanation given is consistent with the injury. With regard to such testimony, the following guidelines should be followed:

- Insist on pre-trial preparation by the attorney presenting you as a witness
- Know the facts of the case well
- If testifying as an expert witness, propose questions for the attorney to ask
- Brief the attorney on questions to ask the opposing expert
- Listen to the question asked and answer only that question
- If a question is not understood, ask that it be repeated
- Do not volunteer information
- Explain when a one-word answer is not enough
- Calmly correct an attorney who misstates prior testimony

Risk Management

Duty to the Victim

Most physicians will encounter cases of domestic abuse in their practices.

Physicians must be aware of their obligations in these cases, as well as their potential liability for failing to diagnose and/or report domestic abuse. In general, doing what is medically best or most appropriate is good risk management. If an injured woman is treated by a physician who does not inquire about abuse or who accepts an unlikely explanation of the injuries and she then returns to the abusive situation and sustains further injuries, the physician could be held liable for those subsequent injuries.

The duty to the victim may arise from the special relationship between doctor and patient or from the courts' interpretations of reporting laws. The argument would be that other physicians, under the same circumstances, would have diagnosed inflicted trauma and taken appropriate management steps that would have prevented the subsequent harm.

Thus, physicians must be willing to ask all women patients about abuse, and should know how to diagnose it. *Failure to conduct the interview and examination apart from the suspected victim's spouse or partner may interfere with an accurate diagnosis.*

Physicians also should be aware of certain "red flags" that can signal particularly dangerous situations for the woman: stalking behavior by the abuser;

substance abuse by the abuser; and threatened suicide by the abuser (increased risk for a murder/suicide).

In states that have enacted mandatory reporting statutes, a physician's failure to report could give rise to liability, but since reporting laws rarely explicitly give victims such a right to sue, courts must determine whether their state's statutes implicitly contain that right. Criminal reporting statutes usually are enacted to inform the police of the occurrence of crimes rather than to protect victims of violence. In contrast, child abuse reporting statutes are usually enacted with the clear purpose of protecting abused children, and some courts have allowed abused children to sue physicians who violate a reporting statute. If a state has a specific domestic violence reporting statute, courts may be more likely to allow a suit against a physician who failed to report the abuse.

Duty To Warn

Many states recognize a legal duty that physicians have toward third parties who might be harmed by their patients. In those states, if a physician is aware of a patient's intent to harm a third party, such as the patient's spouse or partner, the physician may have a legal duty to breach the patient's confidence and to warn the third party of the impending danger. Physicians, especially therapists, should know the law where they practice.

Medical Malpractice Lawsuits

Even after taking all possible measures to handle cases correctly, physicians may still become defendants in medical malpractice suits. These physicians should:

- Not panic
- Not discuss the case with anyone until they have spoken with their attorney
- Contact their malpractice insurance carriers
- Record the circumstances involved in the serving of a summons
- Have thorough documentation

Trends in Treatment and Prevention

Living in an abusive relationship takes a tremendous toll on a woman's physical and psychological well-being. As physicians begin to ask routinely about abuse, they may feel overwhelmed by the prevalence of this problem and by the amount of pain some women experience in their intimate relationships. While maintaining doctor-patient confidentiality, it is important for physicians to discuss with supportive colleagues or others how best to respond to such encounters.

All physicians should begin to respond to the JCAHO requirements of recognition, crisis intervention and referral. Some will play a more active role by developing innovative programs, advocating for increased funding for services and for violence prevention programs, and by educating students, community groups and other physicians. There is much work to be done, but there is a great potential for improving patients' lives, especially when physicians team up with other professionals and work through local community services.

Several recent trends will improve awareness and outreach in the area of domestic violence. These include hospital-based intervention programs that link with community groups and provide ongoing support and advocacy; community-based training projects to educate physicians and other health care providers; new residency requirements and additions to medical school curricula that train physicians to recognize violence and abuse; and the addition of assessment of abuse into existing community outreach programs for women. The AMA is working to assist physicians in their efforts to reduce violence and the effects of violence in their local communities.

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K. UPDATE ON THE AMA'S NATIONAL CAMPAIGN AGAINST FAMILY VIOLENCE

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED:

Report FF of the Board of Trustees, Update on the AMA's National Campaign Against Family Violence (Policy 515.980), recommended that ongoing efforts on family violence continue to be an action item at each of the annual meetings of the American Medical Association and that the impact of drugs and alcohol on family violence be studied and included in future updates. Report G of the Board of Trustees (I-91), A Proposed AMA National Campaign Against Family Violence (Policy 515.986), outlined an action plan of activities to address family violence.

COMMUNICATION STRATEGIES

On June 10 and 17, 1992, issues of the Journal of the American Medical Association (JAMA) and specialty journals were devoted to the topics of "Violence in America" and "Domestic Violence," respectively. The release of these issues was preceded by a press conference held in Washington, D. C. As a result of the excellent reception to these journal articles, a compendium from JAMA, American Medical News and the specialty journals of the American Medical Association, titled "Violence," was assembled and distributed. The compendium represents the most current research and up-to-date literature reviews on the topic of violence and family violence.

NATIONAL COALITION OF PHYSICIANS AGAINST VIOLENCE

The National Coalition of Physicians Against Violence currently has a membership of 4,000. New registrations are received daily. All members of the Coalition receive membership cards, a mission statement, a family violence poster, a newsletter and a set of the four diagnostic and treatment guidelines published by the American Medical Association.

The primary purpose of the Coalition is to provide the nidus for the development of violence prevention committees through local medical societies. This is already occurring in 16 states. Lists of Coalition members have already been sent out to state and local medical societies. In addition, the Division of Communications has developed a project book titled "What You Can Do About Family Violence." The book is designed specifically for use by state and county medical societies, and makes suggestions for the development of violence prevention committees.

A National Advisory Council on Family Violence consisting of representatives from the specialty societies has been organized. Forty specialty organizations have designated representatives. The first meeting of the group was held in Chicago in September 1992. A second meeting of the Council was held in Washington, D. C., on April 1-2, 1993. While still in the formative stages, the Advisory Council is examining issues concerning medical education, federal and state legislation, and the needs of professionals working in the various areas of family violence.

An outgrowth of the Advisory Council's activities includes the formation of a group of medical school deans interested in developing curricula on the different forms of abuse for undergraduate clinical education. Once completed, the model curricula will be disseminated to medical schools around the country.

NATIONAL MEDICAL RESOURCE CENTER

The National Medical Resource Center on Family Violence continues to gather protocols and guidelines which address the various forms of abuse. Through the National Resource Center, the AMA's Diagnostic and Treatment Guidelines on child physical abuse, child sexual abuse, domestic violence and elder abuse have been widely distributed.

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Reports from the various AMA Councils have also been made available through the National Resource Center. In addition to existing reports on violence against women, adolescents as victims and perpetrators and physicians and family violence, the House of Delegates will consider at its 1993 Annual Meeting a report on substance abuse and family violence. Reports on the impact of family violence on mental health and violence against men are currently under preparation.

IMPACTING THE HEALTH CARE SYSTEM

Beginning in January 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) required hospital emergency departments and ambulatory care facilities to meet standards for all forms of abuse: child abuse, sexual assault, domestic violence and elder abuse. The standards require that policies and procedures be in place to address diagnosis, appropriate treatment and referral, and staff education in order to be accredited by the JCAHO. The American Medical Association, the American Hospital Association and the Education Development Center, Inc., of Newton, Massachusetts, have completed a proposal which, when funded, will allow for the development of model protocols and education and training programs to assist hospital staff in complying with the new JCAHO standards.

NATIONAL INVITATIONAL CONFERENCE ON THE PREVENTION OF FAMILY VIOLENCE

A National Invitational Conference on Family Violence will be held on March 11-13, 1994, in Washington, D. C. The Conference will focus on how medicine and the law can work effectively together to address the problems of family violence. National organizations representing medicine and law, leading attorneys and physicians specializing in issues of family violence, and members of Congress interested in family violence will be invited to attend the Conference. Outcomes for the Conference include the development of programmatic activities to be embraced by national organizations and policy recommendations to be delivered to Congress and state governments. A planning meeting for the Conference will be held March 31, 1993. Cosponsorship by the American Bar Association, the American Dental Association, the American Hospital Association and the American Nurses Association has already been agreed upon.

THE AMA'S CONTINUED INVOLVEMENT ON VIOLENCE ISSUES

Family violence, as compared to other more global types of violence, was selected by the Board of Trustees because of its more direct relevance to practicing physicians. Nevertheless, research has shown that violence occurring in the family is carried over to the community. The possibility that children who are victimized may continue to perpetuate the cycle of violence as adults in their own families, as well as the broader community, is an issue receiving attention by the research community.

International homicide rates for males 15-24 years of age suggest that the United States is the most violent country in the world. Our own experiences seem to substantiate this finding given the recent problems in Los Angeles, the number of articles in our newspapers about drive-by shootings, the rising homicide rates, children coming to school with guns, and the often heard denunciation about the amount of violence portrayed on television.

Since the initiation of the Physicians Campaign Against Family Violence in October 1991, the American Medical Association has received extremely positive feedback from physicians, other professional groups and the general public. The Campaign began as an effort to heighten awareness among physicians regarding the abuses constituting family violence and to educate them in appropriate diagnosis and treatment. This work began with the issuing of the AMA Diagnostic and Treatment Guidelines on child physical abuse, child sexual abuse, domestic violence and elder abuse.

The AMA's involvement in the area of family violence has catalyzed a variety of positive responses from the public, the news media, professional organizations, advocacy groups, members of Congress and other governmental

agencies. The AMA is clearly viewed as a leader in this area and has given the issue of family violence a prominence that few other organizations could provide. Indeed, many complementary programs have been launched by constituent societies in the federation as well as by the Auxiliary and other distinguished organizations. The AMA's efforts have also provided a forum for discussion among all those concerned with this issue.

To extend its leadership role in this area of public health, AMA efforts must include coordination and violence prevention. While diagnosis and treatment is of great importance to physicians, a public health approach that places emphasis on primary prevention of violent behaviors is indicated.

RECOMMENDATIONS

The Board of Trustees recommends that the following policy statements be adopted:

I. Recognition, Safety and Treatment

- A. The AMA should provide educational and training opportunities for physicians in diagnosing, treating, and referring cases of abuse constituting family violence;
- B. Work with the American Hospital Association to encourage the development of hospital-based programs for the diagnosis and treatment of abuse among all people, especially in geographic areas of high risk for violence;
- C. Work with the American Hospital Association to encourage the development of multi-disciplinary hospital-based teams of professionals to assist physicians and other health professionals in the diagnosis and management of family violence cases;
- D. Develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education.

II. Coordination of Efforts of Violence Control and Prevention Activities

- A. State and county medical societies should convene or join state and local health departments, criminal justice and social service agencies and local school boards to collaborate in the development and support of violence control and prevention activities. These efforts should be coordinated through state and local health departments.
- B. Hospitals should meet with agencies within their own communities that provide assistance to victims of family violence and develop protocols for working with one another.
- C. Collaborate and coordinate with the Centers for Disease Control and Prevention supported comprehensive school health programs initiative to develop health education curricula for grades kindergarten through 12 on topics including violence avoidance, conflict resolution and enhancement of self-esteem.

III. Primary Prevention

- A. State and county societies should support violence prevention committees made up of physicians and members of the AMA Alliance for the purpose of establishing local agendas;
- B. Encourage all physicians to routinely screen for the effects of violence and abuse in all patients;

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- C. Develop a "train-the-trainers" program on primary prevention for physician members of the National Coalition of Physicians Against Family Violence to work within local school districts to implement educational programs on violence prevention and substance abuse.
 - IV. The AMA should study the problem of domestic violence in doctors' families and make recommendations concerning approaches to recognition and treatment.
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B. VIOLENCE AGAINST WOMEN**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER
OF REPORT FILED:**

The two decades since the 1960s have witnessed a new national awareness of the violence faced by women. Prior to the 1960s, only a few forms of violence — such as assault or rape by strangers or casual acquaintances — were seen as a danger to women. Families were assumed to afford protection against this danger, and women were advised to seek the shelter of their homes in order to remain safe from harm. The study of assaults occurring within families did not begin until the 1960s, with an emphasis on physical child abuse. At this time, there were almost no reports of sexually molested children or abused wives. Violence in the family was thought to be infrequent and to result from the psychopathology in the individuals involved, rather than being viewed as a society-wide problem with far-reaching consequences.

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The new knowledge on violence against women began with the anti-rape movement which, in the 1960s, began to focus on sexual violence against women by strangers and acquaintances. Such discussions revealed the prevalence of women experiencing sexual assaults by intimate males, rather than strangers, and led to the identification of physical assaults of women by male intimates as a phenomenon of previously unrecognized proportions. Studies now document that women in the United States are more likely to be assaulted and injured, raped or killed by a current or ex-male partner than by all other types of assailants combined.

RELEVANCE FOR MEDICAL PRACTITIONERS

There have been earlier periods in U. S. history when the victimization of women and children became topics of special concern. However, the past two decades represent the first time that systematic data on prevalence and outcomes have been gathered or that responses have been so wide-ranging, involving advocacy, medical, mental health, criminal justice, governmental, and academic communities. Major research and police initiatives have been developed to address aggression occurring within families. Rape laws have been amended nationwide to protect victims; in some cases removing the exemption offered for assaults by husbands and ex-husbands. Nearly every state has established new legislation targeted for violence between adult partners, and federal legislation on violence against women is now pending. Although the medical community — along with the criminal justice system — is the most likely to see women victims, and thus constitutes a frontline of identification and intervention and although police and others in the legal community increasingly benefit from training and enhanced procedures in responding to women victims, only rarely are physicians and other medical staff provided with training or specific protocols to aid in dealing with these cases.

In summarizing the concerns of physicians and public health officials, attending the AMA National Leadership Conference, Surgeon General Antonia Novello, M. D., cited a Centers for Disease Control study reporting that violence by intimate partners is the leading cause of injury for women, "responsible for more injuries than car crashes, rape and muggings combined." Novello continued, "But sadly, the medical community has yet to consistently identify these women as victims and extend treatment beyond the physical manifestations of an abusive relationship" (Doctors Urged to Act in "Crisis" of Violence, American Medical News, March 4, 1991).

The cost of a failure to identify and intervene with violence, in terms of patients' suffering and the use of medical providers' time and resources, is incalculable. Particularly with violence by intimates, assaults tend (a) to be repeated over time, (b) to produce more injuries than assaults by strangers, and (c) to have complicated sequelae with implications for further morbidity (e.g., the possible victimization of another family member by the original abuser or victim). The long-term nature of the effects of trauma, the pattern of repeated assaults by assailants in families, and the frequency with which intimate assaults against women result in injury typically mean repeated contacts with victims involving various medical personnel and services, with a low success rate for the alleviation of symptoms. Moreover, as Robert McAfee, M. D., Vice Chairman of the AMA Board of Trustees noted, "In addition to the terrible human toll, violence strains the resources of our health care system . . . When we are being constantly criticized about health care costs, this is one of the factors driving those costs up" (Doctors Urged to Act in "Crisis" of Violence, American Medical News, March 4, 1991).

OVERVIEW OF TOPICS COVERED

This report reviews the following (overlapping) forms of violence against women: rape, physical and sexual assaults by marital or dating partners, and the long-term effects of child sexual molestation in adult women. (Topics of child physical abuse and elder abuse have been covered more generally in other Council publications.) Empirical evidence on prevalence and the physical, psychosocial and emotional outcomes of these types of victimization are reviewed, relevance for the practice of medicine discussed and recommendations for enhanced identification and response presented.

RAPE

In traditional definitions, rape has been defined as the "carnal knowledge of a female forcibly and against her will." The meaning of "carnal knowledge" is restricted to vaginal-penile penetration; other types of sexual penetration are excluded. This definition is used by the Federal Bureau of Investigation (FBI) for its Uniform Crime Reports of offenses known to the police, as well as by the National Crime Survey (NCS) "to measure the extent of unreported crime in the United States. Although data on rape is gathered at the federal level, actual legislation on rape varies by state. In the last two decades, legal definitions of rape have undergone extensive revisions: many states now utilize expanded (or reform) statutes that define rape as the "nonconsensual sexual penetration of an adolescent or adult obtained by physical force, by threat of bodily harm, or when the victim is incapable of giving consent by virtue of mental illness, mental retardation, or intoxication." These reform definitions typically include other types of sexual penetration, in addition to vaginal, as well as attempts to commit rape by force or threat of force.

Incidence and Prevalence of Rape

According to FBI crime reports, a total of 92,486 rapes of women were reported to the police for the year 1988. Approximately 82 percent of these rapes were completed by force; the remaining 18 percent were forcible attempts. This yields a victimization rate of approximately 73 rapes per 100,000 adult women. Estimates based on the National Crime Survey, which includes incidents not necessarily reported to the police, are nearly twice as high: for 1987, the rate of rape victimization was 1.3 per 1,000 women and girls (excluding children under the age of 12) and 0.1 per 1,000 men and boys.

However, parameters of both the Uniform Crime Reports and the National Crime Survey exclude many incidents of forcible sexual assault. Only a small percentage of crimes are reported to the police. Significantly, officials consider rape to be the most underreported of all crime categories measured and, although the NCS is designed to tap the incidence of unreported crime, no specific questions regarding sexual assault are included. The single question to probe for rape asks, "Has anyone attacked you in some other way?" Unless a respondent volunteers information about sexual assault, no further questions are asked. Further, the context of a "crime" virtually guarantees underreporting of intrafamily assaults in both surveys. Marital rape has been exempt from rape laws in most states until recently, and still is almost never reported to police. NCS respondents may view assaults occurring between family members as personal problems, rather than as criminal actions. Further, NCS interviews are frequently conducted with other family members present and thus privacy in responding is not assured.

Epidemiological Studies. Prevalence studies using epidemiologic methods yield more reliable estimates. Such studies now indicate that at least 20 percent of adult women, 15 percent of college women and 12 percent of adolescent girls have experienced sexual abuse and assault during their lifetime. In a study using the California rape statute to define rape as "forced intercourse . . . or intercourse completed when the woman was drugged, unconscious, asleep or otherwise totally helpless and hence unable to consent . . ." and an intensive interview format, 44 percent of a random sample of women had experienced at least one attempted or completed rape. Similarly, in a community study conducted in South Carolina, 23 percent of adult women had experienced a completed rape (defined as nonconsensual penetration involving force or the threat of force), and 13 percent had experienced attempted rape. Estimates for African-American women are even higher. Again using a strict definition of rape and a detailed interview format with a community sample of women in Los Angeles, one in four African-American women, and one in five white American women, reported at least one incident of completed or attempted rape since their age 18.

Incidence figures (the number of new cases within a given time frame) add dimension to these findings. In a study of 2,291 adult women in Ohio, 28 per 1,000 women had experienced rape in the 12 months prior to the survey, based on the traditional FBI definition; using an expanded reform definition, the rate rose to 62 women per 1,000. Even using the more restrictive parameters, these figures mean that one out of every 55 adult women experienced a rape as defined by the FBI during that one-year period. Using reform definitions now adopted by many states, one in 24 women had experienced a rape in the prior 12 months.

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High-Risk Populations. Groups in which the incidence of rape is particularly high include children under the age of 12, adolescent and young adult women up to the age of 25, women on college campuses, minority women, elderly women and the handicapped. Children are most at risk from assaults by family members and other caretakers, and least at risk from strangers (see section on childhood molestation). Similarly, adolescents and young adult women are most at risk for acquaintance and date rape and least at risk from someone unknown to them (see dating violence). Both young adult and older women are more vulnerable to sexual assaults by marital or ex-marital partners than to rape from acquaintances or strangers combined (see discussion of marital rape).

Impacts on Psychological and Social Well-Being

Initial Effects. Initial reactions to sexual assault include shock, numbness, withdrawal and denial. Victims of stranger attacks often are afraid their assailant will return and further harm them, and they may fear retaliation if they contact the police. Victims of attacks by acquaintances or intimates are often stunned that someone known to them or someone they trusted could attack them in this manner. In initial presentations to police or medical staff, victims may appear unnaturally calm and detached (although some physical signs such as shaking or lowered skin temperature are usually present), or they may be crying or angry and emotive.

Typically, there is a lessening of these initial symptoms after the first two weeks and the victim may enter a denial phase, in which there is an outward appearance of adjustment. Those surrounding the victim may comment on how well she has recovered from the trauma and assume that the worst is over. However, studies suggest a period, occurring from two weeks to several months post-assault, in which symptomatology returns and may intensify. It is at this time that the victim may begin a pattern of help-seeking for these symptoms, without informing those she contacts of the rape experience that underlies them.

Long-Term Effects. Research has documented that the "aftereffects" of rape are persistent and long-lasting. Victims often react with chronic anxiety and continued feelings of vulnerability, loss of control and self-blame long after the assault. Common long-term reactions include specific anxiety, nightmares, catastrophic fantasies, feelings of alienation and isolation, sexual dysfunctions and physical distress.

In cross-sectional research, women who have been raped tend to score high on almost every kind of measure of psychological distress, post-assault. In one study, rape victims who were as much as 16 years post-assault were found to have consistently higher levels of fear and anxiety than women without rape experiences. Other long-term effects include mistrust of others, resulting in disruption of personal relationships or styles of relating, the development of phobias, manifestations of depression and hostility, and somatic symptoms. Manifestations of depression may include general apathy or suicidal ideation. Suicidal thoughts are reported in between 33 percent and 50 percent of rape victims in cross-sectional studies. In a community sample of women not seeking treatment, between 17 percent and 19 percent of rape victims made suicide attempts.

High-Risk Groups for Post-Rape Distress. Some studies have found that women who were in situations in which they judged themselves to be safe when they were raped (e. g., at home, with a trusted acquaintance or partner) experience more intense fear and depression after the assault than other victims. Women with prior victimization histories also evidence especially severe aftereffects, particularly depression, as the assault triggers memories of a past assault or childhood molestation. Other factors, such as the level of physical threat, injury and medical complications increase the vulnerability to post-rape symptoms. Although it is often assumed that women who are the victims of stranger rapes are more severely traumatized than those victimized by persons they know, research has not supported this assumption. In comparing victims on measures of depression and anxiety, women assaulted by family members or dates experience as severe levels of distress as women assaulted by acquaintances or strangers.

Posttraumatic Stress Disorder. This complex of effects in the aftermath of rape often meet the criteria for the diagnosis of posttraumatic stress disorder (PTSD). In fact, rape victims are believed to constitute the

largest category of PTSD sufferers. Hallmarks of PTSD include psychic numbing, intrusive reexperiencing of the trauma months or even years after the event, avoidance of stimuli associated with the trauma, and intense psychological distress.

Impacts on Physical Health and Well-Being

Initial Effects. Intrusive thoughts about danger, fears about future victimization, and the physiologic arousal associated with these cognitions not only disrupt social and psychological functioning, but often lead to physical symptoms as well. Immediate medical concerns after rape include injury, infection and documentation. Most hospitals have protocols for intervention with rape victims who present themselves to emergency rooms for medical care and testing. In the first weeks immediately following a rape, physical effects of trauma may include soreness, bruising, rectal bleeding and other injuries. Gastrointestinal irritability, fatigue and chronic fatigue, tension headaches, intense startle reactions, and disturbed sleeping and eating patterns also often are noted.

Long-Term Effects. Specific and ongoing health concerns after rape include gynecological trauma such as vaginal tearing or injuries to the vulva, the risk of pregnancy, and the potential for contracting infections or sexually transmitted diseases. Currently, the risk of HIV infection and therefore of AIDS is of increasing concern to rape victims and those who treat them, and contributes to the sense of fear and of irreparable damage with which survivors must deal. Victims may also seek to escape the pain of rape's aftereffects through alcohol and drugs, further disrupting physical and psychological well-being.

Victims' Use of Health Care Services

Rape victims appear to be frequent users of medical services in the months and years post-assault. Survivors perceive themselves as less healthy and report visiting physicians more often than nonvictims, regardless of the length of time since the rape incident. They are more likely to report symptoms in every part of the body (except dermatology and eyes) than nonvictims. They also report more injurious health habits than nonvictims, including smoking, drinking and overeating. In one study, visits to physicians increased 18 percent in the year of the assault, 56 percent in the following year and 31 percent the year after, compared to previctimization levels. Nearly all victims made visits to primary care physicians in each of the two years after the assault.

Special Considerations for Health Care Providers. Although most emergency rooms have established protocols for rape victims who are seen soon after the incident and acknowledge they have been raped, only a small minority of victims seek this type of assistance. Other victims present to private physicians or emergency rooms with complaints based on the symptoms, but do not disclose that an assault has occurred. Still others do not present until months after the incident, but then contact the medical community repeatedly over time in an attempt to deal with long-term effects and complications. Early identification of rape trauma by medical staff can help demystify nonspecific medical complaints and legitimate patient's distress, as well as enabling the physician to make appropriate referrals to help sources to assist with rape recovery. Some lessening of the emotional and psychological distress may, in turn, result in a lessening of symptoms and thus in the need for medical contacts.

Specific protocols that take into account the victim's relationship to the assailant will also contribute to a patient's well-being and the effectiveness of the treatment provided. As noted earlier, women are more likely to be sexually assaulted by their intimates than by strangers. Procedures developed for the victims of stranger rape work poorly in these cases. Victims of intimate assault are less likely to formally report the assault, either immediately or as a part of a medical history, and thus are unlikely to be assisted under established protocols. Even given rape disclosure, established procedures may not provide medical staff with guidance on what to do if the assailant, e. g., the partner, is present in the emergency room or doctor's office. Yet the long-term effects of partner rape are often as severe, and chances of injury greater, than with stranger rapes. Medical protocols should take this into account through the development of procedures for cases of intimate violence. The physical and sexual assault of women by intimates is discussed further in the following section.

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PARTNER VIOLENCE

Although the danger of victimization by strangers historically has received the most attention, nationally representative studies consistently indicate that women are most at risk from their intimates, particularly from male partners. In a 1985 survey of intact couples, self-reports indicated that nearly one out of every eight husbands had carried out one or more acts of physical aggression against their female partner during the survey year. Although the stereotype of "domestic violence" tends to be that of relatively minor assaults and squabbles, over one-third of these assaults involved severe aggression such as punching, kicking, choking, beating up, or using a knife or a gun. These findings mean that, in an average 12-month period in the United States, approximately two million women are severely assaulted by male partners. Victims of violence by intimates are much more likely to be reassaulted within six months than those attacked by non-intimates. Women who are separated or divorced from their partners are at the highest risk of assault.

As with other types of intimate violence, figures based on national surveys are marked underestimates. Such surveys typically do not include the very poor, those who do not speak English fluently, those whose lives are especially chaotic, and all individuals who are institutionalized, hospitalized, homeless or incarcerated at the time the survey is conducted. Further, estimates are based on only those respondents who are willing to report, even anonymously, acts of violence they have perpetrated or experienced to an unknown interviewer. Researchers on family violence agree that the true incidence of partner violence is probably double the above estimates, or four million severely assaulted women per year. Studies on prevalence suggest that from one-fifth to one-third of all women will be physically assaulted by a partner or ex-partner during their lifetime.

Risks of Partner Violence for Women and Men

Although some surveys suggest nearly equal participation rates for women and men (i. e., that about as many women as men have perpetrated at least one act of aggression: threw something, pushed, shoved, slapped, hit, etc.), some clarifications should be noted. First, in this research, no questions are asked about the context within which these actions occur and thus there is no measure of acts that are undertaken in self-defense. Second, the same surveys find that the frequency and types of aggression perpetrated by women and men in partner relationships differ:

- a. Men perpetrate more aggressive actions against their female partners than women do against their male partners;
- b. Men perpetrate more severe actions — such as punching, kicking, choking, beating up, or using a knife or gun; and
- c. Men are more likely to perpetrate multiple aggressive actions against a female partner during a single incident than are women against male partners.

Even when compared with relationships in which women have perpetrated at least one aggressive act, the offending rate for men for severe violence is 42 percent higher.

Severity of Outcomes for Women. In combination with men's greater average physical strength, these factors lead to quite different physical outcomes for women and men. Women are much more likely to be injured by their male partners than men are by their female partners. In analyzing injury reports from the National Crime Survey in 1980, over 80 percent of all assaults against spouses and ex-spouses resulted in injuries, compared to 54 percent of the victims of stranger violence; victims of marital violence also had the highest rates of internal injuries and unconsciousness.

Homicide figures for the United States also demonstrate the differential risk for women and the severity of physical outcomes of partner assault. From 1976 through 1987, the deaths of approximately 38,648 people over the age of 15 resulted from one partner killing another (including homicides by married, common-law, ex-married or dating partners). Of these deaths, 61 percent of the victims were

women killed by male partners and 39 percent were men killed by female partners. For white couples, the differences were more marked: 70 percent of partner homicide victims were women and 30 percent were men. Rates for all female perpetrated partner homicides have dropped dramatically since the mid-1970s: from 1976 to 1985, there was over a 25 percent decrease in the overall numbers of women killing male partners. This drop was linked with the presence in a state of domestic violence legislation and other services for abused women, such as shelters and crisis lines. This decrease has not been matched by a similar decline in men killing female partners, however. Over one-half of women murdered in the United States are killed by a current or former male partner.

Dynamics of Violence Against Wives

Types of partner abuse reported by women in epidemiologic surveys range from being slapped, punched, kicked or thrown bodily to being scalded, choked, smothered or bitten. In relationships with ongoing severe abuse, typical assaultive episodes often involve a combination of assaultive acts, verbal abuse, sexual assault and threats. The repetition of aggression in families is facilitated by the fact that victims are readily available, the amount of time at risk is high, assaults can be carried out in private, and wife-assault is a relatively low-risk behavior for the aggressor, in terms of identification and sanctions.

Until the mid-1970s, assaults against wives were considered misdemeanors in most states — even when the same action would have been considered a felony if perpetrated against a stranger or an acquaintance instead of a wife — and police were not empowered to arrest on a misdemeanor charge. Orders of protection usually were not available on an emergency basis and typically carried no provisions for enforcement or penalties for violation. Moreover, women who eventually killed their mates in protection of themselves or a child found the plea of self-defense unavailable for their case. Only since the late 1970s have domestic violence laws and the provision of shelters and other services begun to more seriously sanction wife assault and offer some protection to abused women.

Characteristics of Persons Involved in Marital Violence

Victims. Early research on abused women focused primarily on women who had sought special services. Accordingly, knowledge of victim characteristics was initially limited to women whose resources directed them to public assistance. Nationally randomized samples now document the diverse socioeconomic backgrounds of victims; although younger women and women living in poverty are more at risk for both nonmarital and marital violence. However, empirical studies have not found characteristics that differentiate women who are victimized from women who are not, other than their socioeconomic status and the fact that they are abused.

In a review of 52 studies with comparison groups, only one of 42 potential risk markers for women — witnessing parental violence as a child or adolescent — was consistently associated with becoming a victim of marital violence. Studies also suggest that being sexually abused as a child leaves women more prone to revictimization in later life. However, empirically, neither personality factors nor behavioral characteristics distinguished women abused by male partners from nonabused women. Although studies from special populations stress symptomatology, the symptoms that battered women exhibit appear most likely to be sequelae of the violence, rather than its antecedents.

Abusers. Some commonalities have been found among male abusers, however. Men who assault female partners are more likely to have witnessed or experienced violence in childhood, to abuse alcohol, to be sexually assaultive to their wives, and to be at risk for violence against their own or their partners' children than are men in comparison groups of nonabusive males. They are also more likely to be involved in violence toward strangers than men who are not assaultive in the family.

Impacts on Psychological and Social Well-Being

Initial Effects. As would be expected, women victims of a partner's violence have many of the same reactions as other victims. During assaults, the primary focus is on self-protection and survival. Reactions

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of shock, denial, withdrawal, confusion, psychological numbing and fear are common. During, and even after, an assault, a victim may offer little or no resistance in an attempt to minimize the threat of injury or renewed aggression.

Long-Term Effects. Similar to rape victims, long-term reactions in women abused by male partners include fear, anxiety, fatigue, sleeping and eating disturbances, intense startle reactions and physical complaints. As with other types of trauma, abused women may become dependent and suggestible and find it difficult to make decisions alone and, during the period that follows, minimize the danger and personal loss. Effects of trauma are exacerbated by the fact that the aggressor is someone they may love, someone they are supposed to be able to trust, and someone on whom they may depend. Unlike the victims of strangers, victims of marital violence in fact have a legal, financial and role relationship with their assailants, confounding their decisions on what to do about the violence as well as the psychological sequelae. In such cases, perceptions of vulnerability, loss and betrayal or hopelessness may be especially severe. There is also a high prevalence of depression, and suicide attempts are common. Violence at home typically leaves no place in which defenses can be let down.

Impacts on Physical Health and Well-Being

Injuries sustained by abused women range from bruises, cuts, black eyes, concussions, broken bones and miscarriages to permanent injuries such as damage to joints, partial loss of hearing or vision, and scars from burns, bites or knife wounds. The force with which an act is carried out, the number of repetitions of the act and the clustering of different acts together play a major role in determining the amount of injury sustained.

Injuries from domestic violence typically involve contusions or minor lacerations to the head, face, neck, breast or abdomen. These are often distinguishable from accidental injuries, which are more likely to involve the periphery of the body. In a hospital-based study, victims of domestic violence were 13 times more likely to sustain injury in breast, chest or abdomen than accident victims. They are also more likely to have multiple injuries than accident victims, as well as medical evidence of old injuries (e. g., old and new fractures, bruises in various stages of healing). When this pattern of injuries is seen in a woman, particularly in combination with evidence of old injury and with vague complaints of aches and pains, physical abuse should be suspected, regardless of the explanation given for the current condition.

Primary care complaints include chronic headaches, abdominal pains, muscle aches, recurrent vaginal infections, sleep and eating disorders and depression. Abused women may also begin to abuse alcohol or prescription drugs; although in studies of general populations, alcohol abuse does not distinguish battered women from nonvictimized women. In addition, recent research suggests an association with delayed physical effects, particularly arthritis, hypertension and heart disease.

Victims' Use of Health Care Services

In studies of emergency room visits, 22 percent to 35 percent women presenting with any complaint were there because of symptoms relating to abuse. A project funded by the National Institute of Mental Health estimated that 21 percent of all women using emergency surgical services were there for sequelae of domestic violence, that one-half of all injuries presented by women to emergency surgical services occurred in the context of partner abuse, and that over one-half of all rapes to women over the age of 30 had been perpetrated by an intimate partner. Rather than stating abuse as the problem, however, abused women are more likely to present with depression, anxiety, family/marital/sexual problems, and vague medical complaints. Rates are even higher in special care populations. For example, it has been estimated that 64 percent of hospitalized female psychiatric patients are the victims of physical abuse as adults.

Due to the ongoing and injurious nature of domestic violence toward women, abused women may visit physicians repeatedly, with increasingly severe physical trauma. In documenting the repeated nature of abused women's visits to health providers, Stark and Flitcraft found that nearly one battered woman in

five had presented at least 11 times with trauma; another 23 percent had brought 6 to 10 abusive injuries to the attention of clinicians. Unfortunately, in most cases, the victimization history underlying these injuries was never identified.

Special Considerations for Health Care Providers

Battering During Pregnancy. Victims of a partner's violence during pregnancy face the risk of especially severe outcomes. There is some controversy over whether the incidence of marital violence increases during an abused wife's pregnancy; however, it does not cease. Based on a representative sample, the 1985 National Family Violence Survey found that 154 out of every 1,000 pregnant women were assaulted by their mates during the first four months of pregnancy and 170 per 1,000 women were assaulted the fifth through the ninth month. Medical sources suggest that approximately 37 percent of obstetric patients, across class, race and educational lines, are physically abused while pregnant.

Pregnancy is a particularly high-risk time for an abused woman. Advanced stages of pregnancy leave her less able to maneuver to avoid blows or escape an attack, and more at risk from secondary injuries to herself as well as to the fetus. Further, clinical reports suggest that assaults during pregnancy are frequently related to jealousy or anxiety about the upcoming birth, and that physically assaultive actions such as blows or kicks are often directed toward the abdomen. Such assaults can result in placental separation, antepartum hemorrhage, fetal fractures, rupture of the uterus, liver or spleen, and preterm labor. One study found that abused women were three times as likely to sustain injury while pregnant as non-abused women.

Physical abuse may lead to fractures, bruising or hemorrhage. Although few specific studies of the impact on birth outcomes have been done, physical violence during pregnancy has been linked to low birth weight in newborns. Physical or sexual assault may stimulate early labor by irritation of the uterus, premature rupture of the membranes or injury to the reproductive organs. Indirect causes of poor birth outcomes for a woman who is victimized at home include social isolation, diminished personal and social support, inadequate access to prenatal care and other services, inadequate maternal nutrition and a concentration of injury on the reproductive organ systems.

Because of the high incidence of women who are assaulted during pregnancy, those providing pre- and postnatal care have an excellent opportunity to identify this abuse and to reduce the potential negative outcomes. Abused women should be given intensified prenatal care, appropriate for high-risk pregnancies. Guidelines for physicians working in the area also urge that every effort be made to identify women who are victims of abuse, and to provide them with information about their rights under the law and available community, social and legal resources.

Marital Violence and Child Abuse. Unfortunately, risk to the children of abused women does not stop at birth. Studies of the co-occurrence of wife and child abuse document that men who abuse their wives are more likely to be abusive toward children than are nonabusive men, and that extreme violence toward female partners is highly associated with concurrent child abuse. There is also a strong association between severe marital violence and the frequency of child abuse. In a nationally representative survey, more than half the males who were severely violent toward female partners abused their children three or more times during the year prior to the survey.

Conversely, in a hospital-based comparison study based on reviews of all child abuse reports filed at a Boston emergency room for a six-month period, records of 59 percent of the mothers were diagnostic or highly suggestive of a victimization history. This was significantly higher than the prevalence of wife abuse among mothers of children in a non-abused comparison group — 16 percent of mothers in the comparison group had been abused. Surprisingly, the rate of violence against single mothers of child abuse victims was four times the rate of mothers who were married, suggesting the need to consider the possibility of trauma histories in all mothers regardless of their marital status at the time they are seen.

Studies also find that mothers who are the victims of frequent abuse are more likely to victimize their children than nonabused mothers, and that mothers who experience severe violence are more likely to use severe measures in resolving conflicts with their children. Some in-depth research suggests that mothers are up to eight times more likely to physically abuse a child when they are in a violent relationship than when that same mother is with a nonviolent partner. Some child and adolescent abuse is also the unintended result of parental violence. Adolescents who attempt to intervene, and young children who may be in their mother's arms or otherwise in close proximity to her when an attack occurs, are at particularly high risk.

MARITAL RAPE

Although a neglected topic in both the areas of family violence and medicine, empirical research has shown consistently that marital rape is an integral part of the patterns of marital violence. In a random sample in San Francisco, 14 percent of ever-married women reported being raped by a husband or ex-husband, more than twice as many as were assaulted by strangers. Similarly, in a representative sample in Boston, 10 percent of women cohabiting with a spouse or intimate male reported at least one sexual assault occurring in that relationship.

Marital rape has been reported in relationships in which no other forms of physical abuse occur. However, it seems to be most frequent as a form of aggression in relationships in which other violent behaviors are ongoing. Sexual assault is reported by 33 percent to 46 percent of women victims who are being physically assaulted by their partners. Research on severely violent relationships indicates that the most violent assaults often include sexual as well as physical attacks, and that battered women who are sexually assaulted by their partners typically experience more severe nonsexual attacks than other abused women. In severely abusive relationships, violent, forcible sexual assault may occur as often as several times a month.

Sexual abuse is an extremely serious form of marital violence. It is possible to inflict an intense level of physical pain over a long period of time, and to cause a wide range of injuries, from superficial bruises and tearing to serious internal injuries and scarring. The psychological impact of sexual assault by an intimate can also be extreme. Victims of marital rape suffer many of the same reactions as other rape victims and are likely to exhibit particularly severe sequelae, both emotionally and physically (including very severe depression and suicidality). Yet, except for child sexual molestation, this type of violence is least likely to be reported by victims, either to medical care providers or to police, due to the shame of the victims, fear that they will not be believed or belief that forcible sexual relations are the "right" of a husband or male partner. An awareness of the potential for forcible sexual assault in marriage, particularly in cases in which other types of physical abuse have been identified, will enable the clinician to sensitively assess for marital rape as a tool for understanding the etiology of observed symptoms.

COHABITING AND DATING VIOLENCE

Although the prevalence of marital violence has led some researchers to call the marriage license "a hitting license" (at least 30 percent of all couples have had at least one act of physical aggression between them), recent investigations have found at least as high a prevalence of physical assault among dating and cohabiting couples. Findings on "dating violence" are quite new in the social science literature and interpretations of those findings can be problematic. However, studies are limited almost exclusively to students in high school and college. Very little is known about individuals between the ages of 14 and 22 who are not attending school or about those who are past college age and dating or living with their partners despite the fact that many who seek medical services at hospital and community health centers come from these groups.

Dynamics of Dating Violence

Data from the National Family Violence Survey in 1975 documented higher rates of partner aggression among cohabiting couples than married individuals. Similarly, results from the 1985 Resurvey, as well as

responses from students at a midwestern university, indicated a higher level of assaults between cohabitants than in the college sample of dating couples or the national sample of married couples, and higher rates among dating couples than married. As with other types of intimate violence, the risk of injury, and of lethal injury, is quite different for women and men. In one study of college students, women were four times as likely to sustain moderate to severe injuries as a result of dating violence than were males.

Self-reported motivations for perpetrating dating violence also differ. Whereas most women give self-defense or retaliation as their motivation, male respondents were most likely to report that the purpose of their violence was to "intimidate," "frighten" or "force the other person to do something." Violence as a response to sexual denial was also frequently reported by males. If violence occurs once in a dating relationship, it is very likely to occur again, with a mean number of 9.6 incidents. Thus it is not surprising that these assaults may result in injury over time.

Sexual Assault in Dating Relationships

Rape victimization for females is highest in the 16-19 year age group and next highest in the 20-24 year age group, with overall rates about four times as high as the mean for all women. In some research on college campuses, 20 percent to 25 percent of college women reported forcible sexual attempts by a date, and 26 percent of college men reported making forcible attempts or forcible rapes. In one study, 35 percent of male university students reported a willingness to commit rape under certain circumstances (i. e., if assured the rape would not be reported) and adhered to strongly rape-supportive beliefs and attitudes. A carefully administered survey of over 6,000 college students found that 42 percent of women students reported some type of sexual assault, including forcible sexual contact, attempted rape and completed rape. Rapes and attempted rapes involved greater levels of violence than did nonsexual assaults in dating relationships. Rates of rape victimization did not vary significantly based on whether the school was large or small, or located in an urban, metropolitan or rural area. Current estimates suggest that one in 3.6 college women has been a victim of rape or attempted rape during their lifetime. In investigating the incidence of forcible rapes and attempted rapes of adolescent girls, a national survey (based on reports of the perpetrators) estimated a minimum of 540,000 assaults of female teenagers per year.

Increasing Severity of Nonmarital Violence for Women

The reported levels of both nonsexual and sexual physical assaults against girls or women by non-marital intimate partners have increased during the past 15 years. Although some of this may be due to a greater sensitivity to dating and cohabiting violence as an issue, levels of severe intimate violence against women do appear to be increasing. For example, although the rate of homicide victimization for male partners in dating or living-together relationships has varied unsystematically, the rate of females killed by dating or cohabiting partners increased sharply from 1976 through 1987. This may be due, in part, to a lack of interventions targeted for dating and cohabiting partners. Shelters and most domestic violence legislation tend to address problems of safety and access for those who are married or cohabiting. Few, if any, services — except on some high school or college campuses — are structured for individuals assaulted by a dating partner. Thus it is possible that the relationship types with the highest risk for violence, sexual assaults and lethal violence are the ones least served by current societal interventions.

Considerations for Health Care Providers

Violence in dating relationships traditionally has been considered relatively nonserious, with few services or protocols designed to address it. However, recent evidence on the prevalence, morbidity and increasing number of male-perpetrated homicides in these relationships requires serious attempts to identify violence between nonmarried intimates and effectively intervene. Screening techniques to assess for current or past victimization should be utilized for all categories of female patients, regardless of demographic or relational circumstances.

SEXUAL MOLESTATION IN CHILDHOOD

Finally, a history of childhood sexual molestation is highly associated with enduring physical and psychological sequelae, so that a lack of knowledge regarding this history may confuse the medical and psychological picture as viewed by a physician. Child sexual molestation is typically not assessed as part of an adult intake evaluation. However, left unaddressed, the long-term effects in victims can be pronounced. Further, clinical studies indicate an exceedingly high prevalence of child sexual abuse histories in psychiatric patients. Given its salience for treatment providers working with adult (as well as child) populations, the effects of child sexual molestation will be briefly discussed.

Cases of child sexual assault first became recognized in large numbers in the 1970s. Prior to this, sexual molestation of children was thought to be relatively rare and to occur only in the most pathological of families. General practitioners expected to see one or two cases at most in their lifetime. In recent years, however, the American Humane Association has documented an increasing number of reported cases of child sexual victimization and several studies have been conducted. Again, some of the increase in reporting is related to an increase in public sensitivity. In the past, children were primarily at risk from fathers, other male relatives and close family acquaintances. While these risks remain, children today may also be at risk from greater use of outside child care by single and divorced working mothers; the use of foster care as the treatment of choice for abuse within families without adequate screening procedures for foster care settings; and national trends toward living together and shorter marital relationships which may put children at risk from stepfathers and mothers' boyfriends.

Long-Term Effects

Impacts on Psychological and Social Well-Being. Long-term effects of the experience of child sexual molestation include impacts on emotions, self-perception, social functioning and physical well-being. Depression is the symptom most commonly reported among women molested as children. Adult survivors are more likely to report depression and to have been hospitalized for depression than other types of victims or nonvictims. A high incidence of self-destructive behavior, both suicide ideation and deliberate self-harm (e. g., cutting, burning or otherwise inflicting self-injury) has also been found in adult survivors of child sexual assault, distinguishing them even within clinical populations. This includes an exceptionally high prevalence of suicide attempts reported among adult survivors in community and college (up to 16 percent), as well as clinical (up to 51 percent) samples. Symptoms of anxiety or tension, including chronic and severe sleep disorders, anxiety attacks, chronic fearfulness and hyper-vigilance, also frequently are noted in survivors, along with disturbances in adult sexual pleasure and comfort.

Survivors of child sexual molestation also report a general sense of alienation persisting into adulthood, as well as difficulty trusting others, relating to women and to men and parenting. Even in general populations, a high percent of the victims of child sexual molestation continue to feel isolated and stigmatized as adults. Although by no means inevitable, approximately one-fifth of child sexual abuse victims evidence serious long-term psychological effects. These may include disassociative responses triggered by specific stimuli or anxiety-producing stressors, as well as other PTSD indicators such as numbing of affect, chronic states of inappropriate arousal, nightmares and flashbacks. Victims who have experienced abuse by fathers or stepfathers, whose assaults involved genital contact or whose molestation involved force, appear to be at especially high risk for severe long-term sequelae.

Perhaps most troubling is the apparent vulnerability of women who have been sexually abused as children to be revictimized later in life by both strangers and intimates. A persistent vulnerability to re-victimization is one of the most consistent findings in both clinical and empirical literature. In one random sample study, 33 percent to 68 percent of the sexual molestation victims later experienced a rape (depending on the seriousness of the childhood abuse they suffered) compared with 17 percent of women who were not child victims. In a survey of college students, women who had been sexually abused before the age of 13 were the most at risk to later become victims of nonconsensual sexual experiences. Victims of child

sexual abuse also are more likely to be physically abused by husbands or other adult partners when they reach adulthood. Other evidence shows that many women who engage in prostitution were victims of abuse as children, and violence perpetrated against current prostitutes is not uncommon.

Impacts on Physical Health and Well-Being. Many of the long-term physical effects discussed in the section on rape are also seen in adult survivors of childhood sexual abuse. Somatic disorders include abdominal pain, headaches and eating disorders (e. g., anorexia or bulimia). Adult victims may also evidence the effects of venereal disease. In a study of children, sexual victimization resulted in the transmission of venereal disease in 13 percent of 409 victims. Documented sequelae of child sexual abuse include herpes, chlamydia, gonorrhea, syphilis and trichomoniasis. Female victims of child sexual assault also are at higher risk for substance abuse and the development of alcoholism than women without this childhood history. Experiences with child or adolescent sexual molestation may also engender a pattern of early drug use, with cumulative long-term effects.

Special Considerations for Health Care Providers

In patients presenting themselves for medical care, a history of child sexual molestation is almost always masked by other presenting problems. Further, medical and psychological symptomatology may be compounded by revictimization experiences, as well as by other life experiences resulting from emotional or behavioral sequelae. Indications that a history of child sexual abuse should be explored include: (1) symptoms of posttraumatic stress disorder, without an apparent history of current or past rape, dating violence, partner abuse or other trauma; (2) evidence of ongoing severe depression, especially if accompanied by self-harm, including physical disfiguring of the body, eating disorders and/or suicide attempts; (3) evidence of sexual dysfunction or unusual anxiety involving sexual activities or exposure of the body (possibly including medical, and especially gynecological, examinations); (4) early onset of alcohol or drug abuse; (5) childhood history of running away, or placement in foster care or institutions; and (6) a history of repeated physical or sexual victimization.

PSYCHOPATHOLOGY VERSUS THE EFFECTS OF TRAUMA

Clinical studies have identified a high incidence of depression and elevated levels of alcohol and other substance abuse in women victims of violence — particularly those seen in emergency and inpatient settings, sometimes leading to DSM-III-R Axis I diagnoses. Diagnoses of personality or developmental disorders (Axis II) are also frequently assigned to women with histories of rape, child sexual molestation or battering. A personality disorder is a diagnosis of social dysfunction and does not take into account the influence of environmental factors extrinsic to the organization of the personality. It may also be a problematic diagnosis for cases in which a trauma history is present, particularly if that history is not known to the clinician.

For example, in one study of adult women with sexual molestation histories, two-thirds met the diagnostic criteria for posttraumatic stress disorder. However, none had received that diagnosis and, in most cases, dealing with the impact of the childhood trauma was not even considered in treatment. Yet both substance abuse and chronic depression, rather than symptoms of an Axis I disorder, may be the long-term effects of a history of victimization and are frequently found as sequelae to child sexual assault. Similarly, battered women's reactions to the violence they have experienced may approximate behavioral descriptors for borderline or other (Axis III) personality disorders, although the same individual might not have met the criteria for the disorder before the onset of recurring attack. An adapted MMPI (Minnesota Multiphasic Personality Inventory) is now available for the assessment of battered women to accommodate the presence of real danger in their lives.

Clinicians in medical settings suggest that, in many cases, a diagnosis of Posttraumatic Stress Disorder (PTSD) is often the most accurate for victims of intimate violence. The "most common trauma" suggested in the DSM-III-R for PTSD is "a serious threat to one's life or physical integrity, or a serious

threat or harm to one's children . . ."; the discussion suggests that the disorder is "apparently more severe and longer lasting when the stressor is of human design." Further, the presence of ongoing physical or sexual abuse is listed under the "Extreme Stressor" category - category number five on the Axis IV classifications of severity. (The only category more severe is reserved for "catastrophic" events and includes captivity as a hostage and concentration camp experiences.) However, for behaviors to be seen as posttraumatic stress reactions, the trauma must be known - something that is not possible if a detailed victimization history is not obtained and effects are interpreted in isolation.

Given the disruption of developmental tasks and stages, Axis II diagnoses are undoubtedly appropriate for some family violence victims. In other cases, extreme stressors (e. g., violent attack) may contribute to the emergence of a psychiatric disorder. Inclusionary criteria for PTSD, structured for situations in which the primary stressor is no longer present, do not always fit current reactions of victims who are faced with ongoing threat or danger. New designations, now being field tested, may provide expanded classifications to better account for both the reactions of individuals who have been victimized in the past, as well as those who must respond to periodic assault and threat in their present environments.

IMPLICATIONS FOR POLICY AND PRACTICE

Physicians and other health care providers rarely probe for the underlying causes of the injuries they treat. However, a treatment plan based primarily on the treatment of symptoms is ineffective for a victim of violence if assaults are ongoing and thus sequelae continually recur. Physicians and medical staff become frustrated with trauma patients who return frequently with nonspecific and chronic complaints, symptoms that the best medical care seems unable to alleviate. Treating only the symptoms initiates a cycle of patient contacts with medical and mental health service providers, with the attendant risks of increasingly severe and debilitating sequelae for the patient, as well as the exhaustion of resources within the system providing care. A more efficient response over time is for medical professionals to routinely screen for victimization, including intimate physical and sexual assault, in their initial as well as ongoing assessments, and to develop treatment plans that address the cause of the trauma as well as its manifestations. Often, knowledge of a history of victimization provides a starting point from which to disentangle a confusion of presenting complaints and symptoms.

Guidelines for Medical Settings

Structured resources within a medical setting will greatly facilitate effective interventions. Basic components for targeted responses to violence against women include:

Training - to develop sensitivity to these issues, including an awareness of risk factors, indicators estimated prevalence in the general and patient population, sequelae and considerations for health care providers. Training should include becoming familiar with assessment procedures and interviewing techniques as recommended in the setting, as well as with risk assessment, safety planning and procedures for linking to resources. Further, training on interpersonal violence should be incorporated into core curriculums for undergraduate, graduate and continuing education for those in the health professions.

Protocols - to assess for current or past victimization as a routine part of obtaining a medical/psychiatric history. Procedures established for cases in which victimization is identified should be adequate to give specific guidance, based on the type of abuse and the individuals at risk (e. g., protocols for the victims of stranger versus marital or date rape; for a women victim where a child is also at risk). Procedures should also include a system of tracking in which the numbers and types of cases seen can be tabulated and patients who repeatedly evidence abuse can be identified.

Response Staff - within the medical setting if possible to whom victims can be referred. Tasks of response staff would include immediate safety planning, making victims aware of their legal rights, area resources for safety and intervention and services available within the hospital and their community. Staff

would follow up with patients and act as a link with both in-house and community resources. Other tasks of the response staff would include coordination of the tracking system, identification of high-risk (and repeat) cases, and coordination of triage efforts for intensive intervention with special risk cases.

Referral Sources — within the community or area for women victims of violence. Medical settings should make themselves aware of and develop linkages with a variety of area resources including battered women's shelters and crisis services, rape crisis centers and services, services for adult survivors of child sexual abuse, services for homeless women, legal services for women victims, treatment programs for men who abuse female partners, and services for abusive parents. A priority on the development of a wide-ranging referral network, and the maintenance of positive and reciprocal relations with the entities in this network will be of great benefit to patients and their families as well as to medical personnel who would no longer be required to carry the full burden of intervention.

These community resources could work collaboratively with hospitals or practices to see victims in the medical setting or to train staff to become more knowledgeable in these areas. At the same time, the health care community — hospitals and residency training programs as well as individual physicians — might provide in-kind services such as evaluations, screenings and testing. Such services might best be provided on site wherever the community resources are located.

Health Care Goals for Women Victims of Violence

Treatment goals for women victims of violence include the attainment of physical health, mental health and safety from further harm. At the AMA National Leadership Conference, Robert McAfee, M. D., current Vice Chairman of the Board of Trustees, stressed that violence in America has become a "public health crisis of epidemic proportions," and urged doctors to take an active role in finding solutions to the effects of violence on the patients they serve (Doctors Urged to Act in "Crisis" of Violence, American Medical News, March 4, 1991). In a similar vein, Surgeon General Novello has urged that physicians not be deterred in finding a role for themselves in the solution, noting "the human cost alone more than justifies swift action by physicians to reduce these deaths and injuries."

Although the problem of violence against women is pervasive and complex, a place to begin is in incorporating this knowledge into routine questions for assessment, sensitive responses to disclosure and effective referrals to resources.

Routine Screening Leading to Identification of Female Patients Who Are or Who Have Been Victims of Violence. Routine screenings should be carried out at the entry points of contact between women and medical care: e. g., primary care, emergency services, obstetric and gynecologic services, psychiatric services, pediatric care, etc. Protocols to assess for victimization will vary somewhat, depending on the medical context, but should be based on assessment instruments in the scientific literature and address the various types of victimization women experience. Guidelines for obtaining information on a trauma history, identifying coping mechanisms and assessing the potential for further danger are provided by McQueen and Anwar, Patten and colleagues and the American College of Obstetricians and Gynecologists.

Validation of the Experience of Victimization and of Observed Symptomatology as Possible Sequelae. An explanation that many people experience physically aggressive actions from their intimates, that often they are afraid to tell anyone about it, and that such experiences can have painful and even dangerous sequelae should accompany assessments for victimization and characterize professional responses to disclosure. One of the greatest services a physician can provide to a patient is to acknowledge the trauma and validate it as a threat to physical and emotional well-being. In discussing physician's responses to abused women, Anne Filtrcraft, M. D., notes that "the very acknowledgement that domestic violence is going on, and that you and she agree it is a serious problem, is a very powerful and therapeutic first step."

Record-Keeping Regarding Victimization History, Observed Traumata Potentially Linked to the Victimization and Referrals Made. Archival studies of medical records note that victimization histories of

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noted at all, are typically included with a list of symptoms or behavioral problems, e. g., "Patient presented with bruises and minor lacerations. Complaints of chronic back pain, sleeplessness and menstrual irregularity. Reports marital difficulties with some hitting, some evidence of substance abuse." More specific documentation, including (a) indications of a trauma history from the initial screening, (b) what the patient has disclosed about past or current victimization, (c) a description of symptomatology potentially linked to the victimization and (d) referrals made, based on this history provides a basis for later review of treatment plans. Such a record is also useful to assess progress, or to indicate the need for more intensive interventions at a later contact with the patient.

Referral to Within-Setting and/or Community Trauma-Specific Resources. After disclosure of victimization to a physician or other staff, referral should be made as quickly as possible to specially trained staff within the setting or, if none are available (e. g., in a private practice), to outside resources. Whenever possible, these resources should be "trauma-specific" - e. g., rape victims would be referred to those with expertise in rape crisis and/or marital or date rape, abused women would be referred to resources with expertise in domestic violence, and so forth. Consonant with the goals stated at the beginning of this section, referral and intervention procedures should take into account the safety of the woman victim.

Particularly in cases of domestic violence where victims are still with their abusers, protocols need to address (a) the handling of referrals when the assailant is on the premises, (b) procedures for response if the immediate need of the patient is for protection and (c) the context within which the "problem" of ongoing abuse and threat is to be addressed. In a medical setting, such cases are most typically referred for family (or couples) counseling, but are almost never referred to resources designed to deal with women who are or have been victimized by intimates. Physicians and other medical personnel frequently do not even know what resources are available in their area with expertise on wife abuse, rape and date rape, or shelter. Referring a victim to counseling with her assailant is potentially dangerous. If she has no opportunity to work through some issues apart from him, a victim may resist discussing the issues, or completely deny that a problem exists, in an attempt not to anger her partner and further endanger herself.

RECOMMENDATIONS FOR POLICY

The Council on Scientific Affairs recommends that:

1. The American Medical Association, working with members of the federation and other relevant organizations, undertake a campaign to alert the health care community to the widespread prevalence of violence against women, that the effects of such violence are likely seen on a regular basis, and to sensitize them to the needs of victims of violence;
2. The AMA encourage physicians to routinely incorporate screening leading to identification of female patients who are or have been victims of violence;
3. The AMA encourage physicians to give due validation to the experience of victimization and of observed symptomatology as possible sequelae;
4. The AMA encourage physicians to record a patient's victimization history, observed traumata potentially linked to the victimization, and referrals made;
5. The AMA encourage physicians, after diagnosing a violence related problem, to refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible;
6. The AMA encourage the incorporation of training on interviewing techniques, risk assessment, safety planning and procedures for linking to resources into undergraduate, graduate and continuing medical education programs;

7. The AMA collect and disseminate protocols on identifying and treating victims of violence and develop, in conjunction with other relevant organizations, guidelines for treatment where protocols are absent; and
8. The AMA include appropriate information detailing the important role of substance abuse in the etiology, treatment and prevention of violence against women in its efforts.

(References pertaining to Report B of the Council on Scientific Affairs are available from the Office of Science and Technology.)

Mr. TOWNS. Thank you very much, Dr. McAfee. Let me begin by thanking you for your leadership and the things that you are doing in the AMA. I know that you do have to make a flight so we will not ask any questions at this time. However, we would like to leave the record open for 5 days to submit questions to you.

I would like to ask the other members of the subcommittee at this time to refrain from asking questions. If you would like to just sort of make a quick comment, feel free to do so. I promised him that I would get him out on time. If you have a quick comment, any Member can go right ahead, but we don't want to ask any questions. Do you have a comment?

Mr. BARRETT. Very briefly. I just want to say I am delighted to see you here. I am delighted the AMA is taking a proactive role. I think it is very, very important, and I think we all appreciate your being here today.

Dr. MCAFEE. Thank you, very much. If I could share, Mr. Chairman, just one anecdote. I was at the American Academy of Family Practice annual meeting 2 weeks ago in Boston. We were appearing on a three-person panel dealing with domestic violence. We had been looking for some expression of commitment by our specialty organizations, including family practitioners in this endeavor. When they gave us an interesting time and a first opportunity to try an evening CME session, which I thought initially might not be the best time to discuss this, 6 to 8 p.m. in the evening didn't seem the best time to corral the biggest audience. Nonetheless, after the lights were turned up in the Hines Auditorium after our presentation, 2,500 physicians were in that audience to listen to this 2-hour panel on family violence.

I think the commitment by the medical profession is very evident. We need to break the cycle of violence that is engulfing this country, and I am pleased to have the opportunity today to share those thoughts with you very, very much.

Mr. TOWNS. Thank you very much. Mr. Schiff.

Mr. SCHIFF. I just join the statement of my colleagues that we appreciate your being here and the AMA's proactive and aggressive stance on this issue of looking behind why patients are coming in to be treated to see if in this area at least we can avoid that need in the first place. Thank you, doctor.

Dr. MCAFEE. Thank you very much.

Mr. TOWNS. Thank you very much.

At this time what I would like to do is ask Members that might have opening statements, I would like to yield to any Members who might have opening statements.

Mr. SCHIFF. Mr. Chairman, because we have a markup in full committee at 11, I will waive an opening statement. Thank you.

Mr. TOWNS. Thank you very much. I will do likewise. You are right, we have a markup, so at this time I would like to call Congressman Ron Wyden from Oregon. Let me welcome you to the subcommittee and to say that we know of the outstanding work that you have been doing in this area, and we thought it would be good for you to come and share your thoughts with this committee, so you know the rules, and, of course, as was indicated, we have a markup a little later on, so we are a little tight, but we are de-

lighted for you to come and for you to share your thoughts with us, so you may proceed any way you wish.

**STATEMENT OF HON. RON WYDEN, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF OREGON**

Mr. WYDEN. Well, Chairman Towns. Thank you. Let me spare you and your colleagues any filibusters. I would ask unanimous consent to have my statement be part of the record. Maybe I could just——

Mr. TOWNS. Without objection, your entire statement will be included in the record. If you could summarize it in 5 minutes, we would appreciate it.

Mr. WYDEN. I will certainly do so. It certainly seems to me, Chairman Towns, and I want to commend you for your work in this field, that you are hitting the forgotten part of this debate. The Congress has looked at the domestic violence issue from a number of standpoints.

We have looked it from the standpoint of the law enforcement area, we have looked at it from the standpoint of the judiciary, we have looked at it from the standpoint of assistance to community organizations, outreach, these kinds of services, but, in my view, the missing link in an effective strategy for reducing domestic violence is the medical profession, and what is so striking, and I thought the statement from the American Medical Association witness was very good, is that the profession now realizes that there is a great deal more work to be done.

What got me involved in this issue was in 1992 in a journal article of the American, the American Medical Association's journal, Dr. Richard Jones, who was then president of the American College of Obstetricians and Gynecologists, one of the premier leaders in the field, wrote in this article that for years in his practice he had missed the most obvious signs of domestic violence, so we had a situation where the president, one of the renowned people not just in the country, worldwide, was admitting in a premier medical journal that he had missed in his practice signs of physical abuse in women, had been asking the wrong questions, failed to elicit the cause of injuries, and that he felt that the profession had a lot to do to address these issues.

This was backed up by two other important analyses. The Surgeon General's report came out in 1992 citing a report that found that 35 percent of the women who visit hospital emergency rooms are there because of ongoing abuse, and several studies, most recently one done by the University of Oregon Health Sciences Center found that two-thirds of health professionals said that they had essentially had no training whatsoever in terms of how to deal with domestic violence.

So I think this is a pretty good backdrop which suggests, Chairman Towns, how important your hearings are in terms of filling the big gap in America's strategy for dealing with these problems. Congressman Kreidler has done excellent work in this area. The AMA's program is certainly very welcome, and let me just wrap up by outlining another approach that I have felt strongly about.

The medical schools in this country have been slow, in my view, to tackle this issue. In fact, after 1992 we did an analysis across

the country of programs at medical schools and found virtually none were tackling the domestic violence issue.

Now, of course, the Congress through title VII and title VIII of the Public Health Services Act makes available Federal funds for the training of medical providers in our country, so I have offered in several forms legislation that would stipulate that applicants should be getting significant training in identifying the causes of domestic violence, making sure that they are making appropriate referrals to health and community-based organizations as a condition for receiving Federal education dollars.

In working with the various organizations, we have agreed on an approach that is an acceptable condition to all sides and in effect what we have been able to do is get an agreement for the title VII and title VIII moneys that stipulates that in effect there would be a preference for the schools that are willing to have strong domestic violence programs. This way the Congress of the United States is not micromanaging health education. We are not reaching in from Washington, DC to direct how they ought to do this kind of program, but there are a number of good models.

The Department of Health and Human Services can work with the medical colleges to get agreement on these models. The AMA's program is a good one, but what we ought to say at a minimum, given the fact that this issue has gone unaddressed for so long is that the Congress wants to see a preference go for these scarce Federal dollars when a college has a good domestic violence program. And I would like to wrap up by saying that this approach is supported by the American Association of Medical Colleges, the various kinds of other organizations, the NOW Legal Defense Fund, and with that, Mr. Chairman, I thank you for your consideration, and I know the light is on, and look forward to working with you and the committee.

[The prepared statement of Mr. Wyden follows:]

STATEMENT OF REP. RON WYDEN ON
THE DOMESTIC VIOLENCE IDENTIFICATION AND REFERRAL ACT
BEFORE THE SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS
October 5, 1994

Chairman Towns, thank you for inviting me to speak to you today. I think you are holding an important hearing on an important subject. With the passage of the Violence Against Women Act in the Crime Bill, Congress covered domestic violence from a law enforcement and judicial perspective, increased the number of battered women's shelters, and provided funds for outreach and education on domestic violence. However, Congress has overlooked a major resource in the battle against domestic violence -- our health professionals, who are often the first to see the effects of battering and who are often in the best position to stop the cycle of violence before it goes any further.

In a June 17, 1992 issue of the Journal of the American Medical Association (JAMA), Dr. Richard F. Jones, III, the then-President of the American College of Obstetricians and Gynecologists (ACOG), related how for years he had missed the obvious signs of physical abuse in women patients, had been asking the wrong questions and failed to elicit the true cause of their injuries. Only when he started asking these women directly if they were victims of physical abuse did the truth emerge.

A Surgeon General's report that came out in 1992 cited a report that found 35% of the women who visit hospital emergency rooms are there because of on-going abuse -- making domestic violence one of the leading causes of injury to women. More disturbing, the Surgeon General also reported that as few as 5% of the victims were so identified by medical personnel.

Since this report, the American Medical Association has issued model protocols for dealing with domestic violence. Additionally, some health professionals are beginning to promote training in how to identify and treat domestic violence. However, according to a recent survey by the Oregon Health Sciences University, two-thirds of health professionals in my home state of Oregon said they had no training in how to handle spouse abuse.

Health professionals have come a long way since 1992, but the fact is that still when it comes to domestic violence, the bruises and abrasions get dressed, but the cause is going unaddressed. Doctors miss the signs of domestic violence early on and then often miss them again when they are catastrophic.

I have looked at two approaches to providing incentives for medical schools to integrate thorough training in domestic violence into their curriculum. In one approach, we amended Title VII and Title VIII of the Public Health Services Act so that applicants who provided "significant training" in domestic violence would get

preference in receiving funding for the health professions education grant programs.

In crafting this compromise from my original bill, H.R. 3207, I worked with a number of organizations including the American Association of Medical Colleges, National Coalition Against Domestic Violence, American Association of Nurse Practitioners, NOW Legal Defense Fund, American Medical Women's Association, and the National League for Nursing. I do intend to introduce this as legislation next Congress.

In my original bill, H.R. 3207, I proposed to add a domestic violence training and prevention requirement as a condition for receiving grants under in Title VII of the Public Health Services Act. Medical schools and other health professions education institutions would have until 1996 to integrate "significant training in domestic violence" to their curriculum. If they did not add domestic violence to their curriculum their grant money would be cut by 5%, 10%, 15% and 20% each succeeding year until in the fifth year it would be cut entirely.

The Title VII and Title VIII grant programs singled out in my bill are demonstration grants and make up but a small part of the hundreds of millions of federal dollars that go to medical schools for state-of-the-art medical education. It seems to me to be self-evident that if we give medical schools this sort of funding, they should at least give some time to addressing the number one cause of injury to women.

Additionally, it is in our country's best interest that Congress ensure medical professionals know how to identify and treat cases of domestic violence. Women who have been raped or beaten have medical costs that are two and a half times higher per year than non-victimized women (\$401 vs. \$161). In Oregon, Kaiser Permanente has announced they plan to aggressively teach personnel to identify and treat domestic violence because in a basic cost-benefits analysis, it's a lot cheaper to stop domestic violence in its infancy than to wait until the woman ends up in the hospital.

I thank the committee for inviting me to testify today. I think that you have chosen to focus on a formerly forgotten side of the domestic violence debate -- that is domestic violence as a public health issue. I hope in the next Congress we can work to bring public health solutions to domestic violence to the forefront.

Mr. TOWNS. Right. Thank you very much. You can see the gentleman knows the rules. He understands when the red light comes on that his time has expired. At this time we recognize Congressman Kreidler from the great State of Washington, who has been a real leader in this area as well.

Congressman Kreidler, welcome to the committee. You know the rules, at 5 minutes, when the light comes on, you must conclude your statement. Your entire statement will be included in the record, so if you could summarize within 5 minutes, we would appreciate it.

STATEMENT OF HON. MIKE KREIDLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. KREIDLER. Thank you very much, Mr. Chairman. I want to apologize, first off, that I will not be able to stay for any questions, and I apologize for having to come and go that way. This certainly is one of the most neglected issues facing women, the impact of violence and abuse, and I want to commend you for holding these hearings because they are terribly important.

Last year, I was proud to sponsor legislation to establish a special program at the Centers for Disease Control and Prevention to address this issue. The need for such a program was clear.

My written statement outlines some of the devastation that domestic violence and sexual abuse afflict on women, not only the injuries themselves, but the aftereffects that can range from gastrointestinal illness to substance abuse to post traumatic stress disorder. However, the public health community is ill-prepared to respond to these victims.

Doctors and other providers regularly ignore, deny, minimize or misunderstand their patients' abuse. Health professionals rarely initiate discussion on this subject. In fact, fewer than 2 percent of the sexually abused women in one study had ever discussed their abuse with their physician.

Another study reported that fewer than 5 percent of the women seeking treatment for injuries were correctly diagnosed by medical personnel as being victims of domestic violence. There is much to be done, and there are too few resources to accomplish it all.

Some physician groups, as Congressman Wyden pointed out, like the AMA, have developed educational materials for their membership, and they are certainly to be commended for doing so. The Family Violence Prevention Fund has initiated a public education campaign that I believe we are all familiar with called "There's No Excuse," which is greatly needed. The CDC program has several goals that I would like to touch on.

First, in my mind their mission should be to educate health care professionals. I worked as a health care professional for over 20 years, and I know how important it is to understand how these questions are phrased, how you develop the conversation and discussion with the patient to develop the kind of case study that is important. The CDC should put resources in developing and disseminating model training curricula on the identification of victims of domestic violence, examination, treatment, documentation, intervention, and referral to other services.

In addition, the CDC must define appropriate interventions in the public health community to identify and help victims. The CDC must collect relevant epidemiological data so that they may know the incidence and prevalence of violent injuries among women and their following health effects. And as it does with other threats to public health, the CDC must help educate all Americans about the growing epidemic of violence.

The appropriation for fiscal year 1995 is \$7.3 million, which is clearly not enough to fulfill all of these goals, and I would certainly urge all of us to support additional funding for these crucial programs. At the same time, it is essential that with limited resources the CDC make effective use of these scarce funds.

I hope that the bulk of these funds will be targeted to projects that can have a direct impact on women's lives, rather than costly research projects that sometimes can be of dubious value. I hope the research can be conducted that will be relevant and not duplicate what we already know about the syndrome of violence.

I hope the interventions that are developed will be aimed at victims' needs and not at offender programs, and will emphasize a consistent community-wide response to domestic violence. I hope the Center for Injury Control and Prevention will do a better job than it has of reaching out to the advocates in the domestic violence community, because they are the real experts on these issues and need to be consulted.

All these concerns can be addressed with appropriate sensitivity and understanding about the complex issue of domestic violence and with a forceful commitment from Congress to making this a priority. This hearing is an important step in that process, and, again, I applaud you, Mr. Chairman, and the committee for your commitment to this issue. Thank you very much.

[The prepared statement of Mr. Kreidler follows:]

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TESTIMONY OF CONGRESSMAN MIKE KREIDLER
PUBLIC HEALTH IMPLICATIONS OF DOMESTIC VIOLENCE
SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL OPERATIONS
COMMITTEE ON GOVERNMENT OPERATIONS

October 5, 1994

Thank you, Mr. Chairman, for inviting me to be here today. One of the most neglected health issues facing women is the impact of violence and abuse, and I commend you for conducting this important hearing.

Last year I was proud to sponsor legislation to establish a special program at the Centers for Disease Control and Prevention to address this issue. The need for such a program was clear: Each year, millions of women suffer injuries from domestic violence and sexual assault. Up to a third of emergency room admissions of women are due to battering. Women who have been abused use the health care system more often than non-abused women -- not simply for treatment of the immediate injuries from violence, but for other health problems abuse can cause -- gastrointestinal problems, reproductive health problems, and stress-related disorders.

Abuse can have a profound effect on a victim's mental health: Women who have been raped are twice as likely to suffer a major depression, three times as likely to abuse substances, and eight times as likely to attempt suicide as non-victims. There are more women in this country suffering from Post-Traumatic Stress Disorder than Vietnam veterans.

Battering is a serious health risk for pregnant women. In fact, one in six pregnant women are victims of abuse during pregnancy. The consequences of battering during pregnancy can include stillbirth, miscarriage, and low birthweight babies.

Adolescent girls who have been sexually abused are more likely to start smoking earlier and more heavily, to abuse drugs, to become sexually active earlier, to have more sexual partners, and to become pregnant. Clearly, if we are to address some of our most serious public health problems today -- AIDS, cardiovascular disease, and substance abuse -- we must acknowledge the chronic, devastating effects of violence.

The reality is, however, that the public health community is ill-prepared to respond to these victims. Doctors and other providers regularly ignore, deny, minimize, or misunderstand their patients' abuse. Health professionals rarely initiate discussion on this subject. In fact, fewer than two percent of sexually abused women in one study had ever discussed the abuse with a physician. Another study reported that fewer than five percent of women seeking treatment for injuries were correctly diagnosed by medical personnel as being victims of domestic violence.

There is much to be done, and, as you can imagine, too few resources to accomplish it all. Some of the physician groups have developed educational materials for their membership and they are to be commended. The Family Violence Prevention Fund has initiated a public education campaign called "There's No Excuse," which is greatly needed.

The CDC program has several goals. First in my mind is the mission to train and educate health care professionals. CDC should put resources into developing and disseminating model training curricula for the full spectrum of health specialties that address the identification of victims of domestic violence, examination and treatment, documentation, intervention, and referral to appropriate social and legal services. In addition, the CDC must help define appropriate interventions in the public health community to identify and help victims. The CDC must collect relevant epidemiological data so we may know the incidence and prevalence of violent injuries among women and their health effects. And, as it does with other threats to the public health, the CDC must help educate all Americans about the growing epidemic of violence.

The appropriation for FY 1995 of \$7.3 million is clearly not enough to fulfill these goals, and I would urge my colleagues to support additional funding for this crucial program. At the same time, it is incumbent upon the CDC to make the most effective use of these scarce funds.

I hope that the bulk of these funds will be targeted to projects that can have a direct impact on women's lives, rather than costly research projects of dubious value. I hope the research that is conducted will be relevant and not duplicate what we already know about the syndrome of violence. I hope the interventions that are developed will be aimed at victims' needs and not offender programs, and will emphasize a consistent, community-wide response to domestic violence. And I hope that the Center for Injury Control and Prevention will do a better job than it has of reaching out to advocates in the domestic violence community who are the real experts on this issue.

All of these concerns can be addressed with appropriate sensitivity and understanding about the complex issue of domestic violence, and with a forceful commitment from the U.S. Congress to making this a priority. This hearing is an important step in that process, and I applaud your own commitment to this issue.

Mr. TOWNS. Thank you, Congressman Kreidler, and let me thank both of you for the outstanding leadership that you have provided in this area. I think you are right. There is no one solution. But I think that if we work together we can come up with solutions. I think the medical profession, in particular, is very important in this process. I look forward to working with you and making certain that this problem is dealt with in a very effective manner. At this time I yield to my colleague, Congressman Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman. Mr. Chairman, because of the time of all involved, I will refrain from asking any questions of the witnesses, but I just want to make one brief but I think important observation. When there are issues that divide us by sides of the aisle, by Republican versus Democrat, those issues tend to get the greatest amount of news coverage, but I think that this hearing and the testimony we have just heard substantiates to me that 90 percent or more of what the Congress works on day in and day out is not divided by any kind of party label, and that Republicans and Democrats and independents have common goals to solve common problems. And although the solutions aren't easy to come by certainly, we are all working together to achieve those goals, and I just want to say that I am very proud to reach across the aisle and commend our two witnesses for their leadership on this issue.

I believe they both testified before this subcommittee in the past on the same issue, and hope they will testify again, and I look forward to working with them. Thank you, Mr. Chairman.

Mr. TOWNS. Thank you very much. At this time I yield to Congressman Barrett.

Mr. BARRETT. In the interest of time, I will pass on any questions.

Mr. TOWNS. Thank you very much. Let me say I agree with my colleague that this is not a Republican or a Democratic issue, battered women. I think that it is a serious problem, and I think that we have to come together as Republicans and as Democrats to see what we can do to bring about a solution.

I look forward to working with both of you to do that.

At this time I would like to call our next witness, Dr. Mark Rosenberg, the Director of the National Center for Injury Prevention and Control, which is part of the Centers for Disease Control and Prevention. Dr. Rosenberg is primarily responsible for overseeing the CDC domestic violence initiative.

Doctor, we welcome you to the committee and let me indicate to you that your entire statement will be included in the record. If you could just summarize within 5 minutes.

You may proceed any way you wish.

STATEMENT OF MARK ROSENBERG, DIRECTOR, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. ROSENBERG. Thank you, Mr. Chairman. I have less practice in keeping within the 5 minutes, but I will try. I am from the National Center for Injury Prevention and Control at CDC, and I want to tell you about a new partnership and a new approach that I think is going to really transform the way we think about family

and intimate violence in this country. I want to acknowledge your support, your help, and that of Congressmen Kreidler and Wyden.

What has also been very, very important, and perhaps even more important is the help and support of a group that is not represented here yet, and that is the women, the advocates, the mothers and the daughters who have been working in this field for a very, very long time, and we do need a closer partnership.

We are getting that started. Let me tell you about it. Let me tell you about what is happening. Why is it a public health problem? First, we call it a public health problem because of the large toll that it takes. About 2,000 women a year are killed as victims of family and intimate violence, 2,000 women killed, and that is the tip of the iceberg.

Less than 1 percent of the women who are beaten and battered are represented by that 2,000 dead women. It is a big, big problem. The toll in terms of morbidity and mortality is huge, so we address it as a public health problem. Second, we call it a public health problem because we have tremendous resources that we can bring to bear on this. You have heard the health care reform debate. We have a trillion-dollar health care industry. Let's involve it, let's bring it to bear on solving this problem.

What can public health do for this? Let me tell you about three extraordinary things that I think public health can bring to and do for this problem. The first is a focus on prevention rather than treatment. Prevention, not treatment. We have to provide shelters for women who are battered, but we have to make it unnecessary for there to be shelters. If we are effective, we can stop it from happening before it starts. That is the focus on prevention.

It is not enough to lock people up, it is not enough to patch them up, and it is not enough to give them shelter when they need it. We have to make it so that they don't need it. That is our responsibility, and if we can prevent and reduce violence in the home, we can prevent that violence from spilling on to the streets. Primary prevention, very, very important.

Second, we can use science and bring science to bear on this question. This has been done very effectively in the past. Science has brought about some miracles in our time. It eradicated smallpox from the face of the earth. It brought down the motor vehicle injury death rate so it is safe to drive long distances now. We can apply that same approach to this issue. And I will tell you how with some more details later.

Third, we can bridge the gap that we have been talking about. Public health believes in bringing together doctors, lawyers, educators, people who work in labor and give jobs to kids and give jobs to women, people who can change the way people live and the housing conditions. It is more than just doctors and nurses in hospitals. We do believe we have to bridge that gap, and we do have to bring together conservatives and liberals, Republicans and Democrats, just as you said. It is not because an idea is a liberal idea that makes it good. They have some very, very silly ideas, and so do conservatives.

We have to take the best ideas and see which ones work, and we can use science to help us find out which ones work. Science holds great potential in this. We also have to bring together other part-

ners, and as hard as it is to bring together the conservatives and the liberals from your vantage point, you know it is just as hard to bring together different parts of government; just as hard, but it is happening.

There was an interdepartmental working group that addressed family violence and they had representatives from the Department of Justice, Education, HHS, the Office of Drug Abuse Policy—lots of people are coming together. It is happening, it is changing. So we can bring together the different forces and get it all together.

What is happening now as a result of this approach? You heard that we do have \$7.3 million to do something. Let me tell you what we are doing. I hope you are proud of what your government is doing because I think this is an exciting area.

There are four things we are doing. First, we want to describe and track the problem. Who does it happen to? How often? Under what circumstances? How many women are beaten? How many children have their lives destroyed by observing violence? We need to establish a common language. We need to establish common definitions. We need to get beyond the debate about which number and what nuance and we need to do something about the problem, but we need to start by a better way to keep track and a better way to talk about it together.

Second, we need to increase our knowledge about the causes and the consequences. Why does it happen to that woman? Why was she stabbed to death? Why was this kid beaten? Why this man? Why our neighbor? Why our sister? Better knowledge about the causes and consequences.

We need better information about how to prevent violence, what works, what interventions make sense, which ones don't. We need to test them out.

The fourth question is how do we do it, and to find that out, we need closer working relationships with the people who are already working in the field. We need to find out how to communicate to people, how to talk to them about what is happening, how to change the very way that they think about this problem. We are just working to get it started. We are working to get it all together. I think all these things are happening. I think it is going to be some exciting changes that you see.

We are not the sole people who act in this. There are other agencies in the Public Health Service, other parts of the administration that are working on it. There are people in State and local governments whom we are trying to bring together, and there are advocates that we are trying to bring together. I think it is happening. It has at least started. Thank you, Mr. Chairman.

[The prepared statement of Dr. Rosenberg follows:]



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

Testimony of

Mark L. Rosenberg M.D., M.P.P.

National Center for Injury Prevention and Control

Centers for Disease Control

Public Health Service

Department of Health and Human Services

Before the

Subcommittee on Human Resources and Intergovernmental Relations

Committee on Government Operations

U.S. House of Representatives

October 5, 1994

Thank you, Mr. Chairman and members of the Subcommittee for this opportunity to testify on family and intimate violence as a public health issue. I am Mark Rosenberg, Director of the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention (CDC) in Atlanta. I am here today to help you bring attention to the problem and to talk with you about the role public health can play in preventing family and intimate violence.

FAMILY AND INTIMATE VIOLENCE IS A PUBLIC HEALTH PROBLEM

Family and intimate violence must be considered a priority public health problem because of the extraordinary toll it takes on our society. Women are frequent targets of both physical and sexual assault by partners and acquaintances. In 1991, 5,745 women died as a result of homicide. Six of every ten of these victims were murdered by someone they knew; about 3 out of these 6 are murdered by a spouse or intimate acquaintance. Although over 99% of assaults on women do not result in death, they still result in physical injury and severe emotional distress. Injuries suffered by victims of family and intimate violence represent tens of thousands of emergency department and physician visits. In many instances, health care providers are unaware of the extent of the violence, are unsure how to communicate with the victims and do not know how to identify and refer the victim for additional help.

Public health complements the criminal justice approach to family and intimate violence. Criminal justice emphasizes punishment, deterrence, and incarceration, while public health focuses on primary prevention. Public health also brings personnel and resources from the physical and mental health care systems together with the law enforcement, judicial, and penal systems to address the problem. Recognizing that family and intimate violence is a public health problem does not mean, however, that public health can solve the problem alone. The criminal justice and public health sectors must work together to solve this problem.

CONTRIBUTIONS OF THE PUBLIC HEALTH APPROACH

The public health approach to family and intimate violence focuses on prevention rather than treatment. Although we must be ready to provide care for women who are victims of violence, we must also find ways to prevent this violence from occurring. We need to look more diligently for ways to break the cycle of violence and stop a pattern that often begins in infancy and childhood and carries over into adulthood. To move beyond locking up offenders will require a radical shift in the way we think about violence in our society. We should not be surprised if this simple idea -- the importance of thinking about prevention -- takes a long time to take hold.

The public health approach is based on scientific data to understand the problem and identify solutions that work. Four simple steps characterize this scientific approach. In the first step, we ask the question "What is the problem?". To answer this question we use epidemiological analysis of large numbers of cases to look for the underlying patterns (who, when, and where) that help to characterize the problem. During the second step, we ask "What is the cause of the problem?" and proceed to answer by looking for causes and factors that may increase people's risk. For the third step, we ask "What works to prevent this problem?". To address this question, we use what we have learned about the patterns and causes, to identify and evaluate interventions that could prevent the problem. The fourth step asks, "How do we implement these interventions?". Effective interventions must be put into place at the community, state, and national levels. This four-step approach has led to dramatic successes, from smallpox eradication to the prevention of motor-vehicle injuries and to public awareness and policies which address tobacco use and its serious health consequences. This approach can have an equally impressive impact in preventing injuries and deaths from domestic violence.

The public health approach stresses the importance of bridging the gaps between different disciplines, different parts of government, the private and public sectors, practitioners and researchers, racial and ethnic groups, and punishment and prevention. The prevention of family and intimate violence will require input from a broad array of disciplines within medicine and medical care institutions and beyond, including education, sociology, criminology, psychology, law, economics, and engineering. In addition, effective solutions will need to bring together academics and practitioners and bridge the gap that exists between those who want to study the problem first to find out what works, and those community members and practitioners who sense the urgency to do something now. One way to bridge this gap is to start some programs now and evaluate them intensively, adopting a "learn as we go" approach. Effective prevention programs will also have to be community-based, because the success of a program may be as much a function of how well that program is connected to the community as well as how well it is designed.

I would like to recognize our federal partners in the effort to combat family and intimate violence, including the Departments of Education, Housing and Urban Development, Justice, Labor, and the Office of National Drug Control Policy. CDC and other agencies within the Department of Health and Human Services are honored and excited to join these departments in the Interdepartmental Task Force on Violence. This task force is spearheaded by the Departments of Justice, Health and Human Services, and Education. The task force's working groups are focused on finding solutions

for preventing violence within our communities, schools, and families.

The Violence Against Women Act, a part of Violent Crime Control and Law Enforcement Act of 1994 (the Crime Bill), will strengthen our nation's efforts to help protect women from violence. For example, the Education and Prevention Grants to Reduce Sexual Assaults Against Women authorize \$35 million in FY 1996 for the Department of Health and Human Services to supplement Preventative Health and Human Services Block Grant funds for rape prevention and education programs to increase awareness and prevent sexual assault. Another provision of the Crime Bill authorizes the injury prevention program at CDC to conduct a study to obtain a national projection of the incidence of injuries resulting from violence against women, the cost of injuries to health care facilities, and recommend health care strategies from reducing the incidence and cost of injuries resulting from family and intimate violence.

WHAT ARE WE DOING ABOUT THE PROBLEM?

In FY 1994, Congress provided CDC with \$7.3 million to conduct activities related to preventing injuries and deaths caused by violence against women. The primary focus is preventing violence against adolescents and adult women that occurs in the context of families or intimate relationships. CDC's program has five broad goals. I would like to describe our activities in each of these areas and give you some examples of the projects we are undertaking.

Describing and tracking the problem.

Currently, we are unable to determine how often violence against women occurs; which women face the greatest risk; how many people, including children and family members, are affected; and whether the problem is improving or worsening over time. Without this information, we cannot determine whether existing prevention programs and services are appropriately targeted or whether existing prevention strategies are working.

CDC will develop data gathering systems that will tell us how often violence against women occurs, which women face the greatest risk, and whether the problem is improving or worsening over time at national or local levels. As part of this effort, CDC will work to:

Establish uniform definitions. During FY 1995, CDC will convene a working group of experts in the field who will decide how to define violence against women and other key variables, such as injury severity, severity of violence, and weapon use. As we have seen recently, there are differences in the way various groups count and determine the size of the problem of domestic violence. We need to come to an understanding of how to

communicate about this problem. We need to speak the same language. The problem is too critical to get lost in a debate about the numbers. The definitions and variables developed by the working group will be incorporated into monitoring activities to be carried out by the states.

Conduct a national survey. CDC currently is supporting a national survey on violence against women through an interagency agreement with the National Institute of Justice. The survey will be used to estimate levels of intimate partner violence and assess knowledge, attitudes, behaviors, and health outcomes (e.g., injury) regarding family and intimate violence in the general population.

Assess the utility of existing data sources. CDC will assess the utility of existing data sources and seek ways to improve them. For example,

HMO Study. CDC is conducting a study of two major health maintenance organizations (HMOs). This study will use automated data systems to compare the use and costs of the medical care system by women identified as abused and women not known to be abused. It will also assess changes in medical care utilization and costs after identification.

PRAMS/GA Health Survey. CDC is developing a violence against women module which will be included in CDC's Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS collects information on risks and health outcomes from a random sample of women who have recently given birth. Information on violence against women and how it may affect pregnancy outcomes will also be collected through a similar module to be added to a reproductive health survey of women, from age 15-44, in Georgia.

Increasing our knowledge of the causes and consequences.

Violence against women, because of its intimate and personal nature, is a difficult problem to study. Consequently, much remains unknown about the factors that increase or decrease the likelihood that men will behave violently towards women, the factors that endanger women or protect them from violence, and the physical and emotional consequences of such violence for women and their children. Greater knowledge of modifiable factors associated with violence against women and the consequences of such violence will lead to the development of new prevention strategies.

CDC will support prevention-oriented research that will lead to greater knowledge of modifiable factors associated with family and intimate violence, specifically violence against women and the development of new prevention strategies. This will occur through extramural research grants and intramural projects.

Extramural research. Eight extramural research grants were awarded during fiscal year 1994 to identify modifiable risk factors associated with family and intimate violence and evaluate the effectiveness of a broad range of intervention activities.

Demonstrating and evaluating ways to prevent violence against women. There are many approaches to preventing violence against women. We need to know far more, however, about how effective specific interventions are and how to combine interventions into effective programs that can be implemented in communities, workplaces, schools, and other settings.

CDC funded three state health departments at the close of fiscal year 1994. Three state health departments were funded through a competitive process to address family and intimate violence issues. The states will inventory existing data sources and prevention programs; systematically collect data on incidence of intimate violence; plan, implement, and evaluate interventions specific to violence against women; and assess the health department's organizational capacity to address intimate violence.

CDC funded four multifaceted community-based projects at the close of fiscal year 1994. These projects will identify successful methods for delivering family and intimate violence interventions at the community level and determine if multifaceted, community-based programs can reduce rates of violent behavior, injury, and death associated with family and intimate violence.

NAS/IOM Study. CDC is currently co-sponsoring and supporting a study to characterize and assess family violence interventions. The study is being conducted by the Board on Children and Families, under the joint aegis of the National Research Council's Commission on Social and Behavioral Sciences and Education and the Institute of Medicine (IOM). The purpose of the study is to convene a committee of 16 experts from relevant disciplines to develop a synthesis of the pertinent research and expert opinion; to document the costs associated with family violence in the United States; to develop a framework for clarifying what is known about suspected risk and protective factors associated with family violence; to characterize what is known about selected interventions in dealing with family violence; and to identify policy and program elements that appear to improve or inhibit the development of effective responses to family violence.

NSF Study. In fiscal year 1995, CDC and the National Science Foundation (NSF) will co-sponsor a study of gun use in American households. The study will investigate the effects of question wording and other survey characteristics on the reported incidence of protective use of firearms in U.S. households;

collect detailed information on the incidents involving the defensive use of guns; and investigate patterns of gun ownership and use by females.

Supporting a national communications effort. CDC's national communication activities include sharing information with organizations across the country who work in the area of family and intimate violence, training, and public awareness. Communications activities will attempt to change attitudes by emphasizing that family and intimate violence, especially violence against women is unacceptable and can be prevented. During all parts of the development process, we will solicit the input of people who have been working in this area and of women who are victims.

In CDC's 1995 appropriation of \$45 million for injury-related activities, Congress has funded an effort to compliment a national media campaign designed to increase public awareness and public involvement in ending domestic violence. The funds provided will support grants that develop and implement local organizing strategies within communities. Priorities will focus on expanding community education and outreach activities. This includes the development of coordinated community domestic violence task forces to more effectively reach racial, cultural, and ethnic and language minorities, development and presentation of community education seminars and other forums to educate the community about domestic violence and dissemination of educational materials used to increase community awareness.

Inventory. CDC will conduct a nationwide inventory of all existing surveillance systems, research projects, prevention activities, public information campaigns, and training programs for professionals and women at risk. The inventory is absolutely essential to the development of communications activities. We need to know the full range of activities in order to communicate the information to others.

National Awareness Campaigns. CDC and the National Resource Center funded by the Administration on Children and Families will provide support to local, state, and national domestic violence organizations during the implementation phase of CDC's recently launched national public awareness campaign, "THERE'S NO EXCUSE FOR DOMESTIC VIOLENCE." The project will provide coordinated training, information, and technical assistance designed to prepare domestic violence programs and leaders in the field to respond to the heightened interest in domestic violence and the increased demand for domestic violence services expected to be generated by the national media campaign. The first training session was held September 12-13, 1994, in Washington, D.C.

Education/Training Evaluation. At the close of fiscal year 1994, CDC entered into contracts to evaluate two programs for training

health care providers in the identification, referral, and treatment of victims of family and intimate violence to be evaluated this year by CDC. A medical school training program at U.C.L.A. and a hospital-based training program in Minnesota will be evaluated. Evaluation of education and training for health care providers may also occur through our extramural research grants, state and multi-faceted community-based cooperative agreements.

Fostering a nationwide network of prevention and support services. There are many public and private organizations and agencies across the country which are currently working on some aspect of preventing violence against women or which are providing care and treatment of women who are victims of violence. CDC will support private/public partnerships, coalitions of national organizations, and will provide support to state and local health departments to coordinate prevention and treatment activities.

Networking. CDC will plan and execute a system for identifying organizations, both public and private, that work to prevent family and intimate violence. This will be partially accomplished through the inventory. We will assess the feasibility of producing a newsletter or other ways of enhancing communication among members of the coalition. CDC will work with the PHS Office on Women's Health to coordinate activities on this important public health problem with other agencies of the Public Health Service to increase research, improve access to services, and increase public and health care provider education.

CDC has a good working relationship and has co-sponsored the "Conference on Family Violence: Health and Justice" with the American Medical Association which was held in Washington, D.C. on March 11, 1994. CDC was a partner in co-sponsoring the National Black Women's Health Conference held in Atlanta, June 30-July 3, 1994.

FUTURE CHALLENGES

It is essential that we continue to forge ahead to find out what works in preventing family and intimate violence and that we work together to stop this problem before it occurs. A major focus for CDC will continue to be funding and evaluating community-based programs aimed at preventing family and intimate violence among high risk populations.

In conclusion, the development and implementation of public policies and proven interventions that lead to the prevention of family and intimate violence is a formidable challenge. The problem of violence against women did not appear overnight; nor will it disappear suddenly. A sustained and coordinated effort to prevent family and intimate violence is necessary at all

levels of society for addressing this complex and deeply rooted problem. I believe, however, that the new vision for prevention put forth by the public health community provides fuel for optimism. Thank you.

**Questions and Answers
National Center for Injury Control and Prevention
Centers for Disease Control and Prevention (CDC)**

**Domestic Violence: A Public Health Issue
House Subcommittee on Human Resources and Intergovernmental Relations**

Question 1: Why is domestic violence a public health problem?

Answer 1: Domestic violence must be considered a priority public health problem because of the extraordinary toll it takes on our society. Women are frequent targets of both physical and sexual assault by partners and acquaintances. In 1991, 5,745 women died as a result of homicide. Six of every ten of these victims were murdered by someone they knew; about 3 out of these 6 are murdered by a spouse or intimate acquaintance. Although over 99 percent of assaults on women do not result in death, they still result in physical injury and severe emotional distress. Injuries suffered by victims of family and intimate violence represent tens of thousands of emergency department and physician visits. In many instances, health care providers are unaware of the extent of the violence, are unsure how to communicate with the victims, and do not know how to identify and refer the victim for additional help.

There are three ways that the public health sector is uniquely suited to make important contributions to the prevention of deaths and injuries from domestic violence:

- **Public health introduces a primary prevention focus to the problem of domestic violence.** Effective interventions can be designed to prevent behaviors and injury outcomes before they occur.
- **Public health brings a set of practical, proven, and goal-oriented principles to achieve the goal of preventing domestic violence.** The approach of describing the magnitude of a problem, analyzing the characteristics of the problem, designing and implementing interventions, and evaluating the interventions has been effectively applied to a wide range of noninfectious and infectious disease public health problems.
- **Public health can mobilize a broad array of existing resources in medicine, mental health, social services, education, and substance abuse prevention toward the goal of preventing injuries and death from domestic violence.** Domestic violence is a complex problem and a number of promising community-based interventions must be tried and evaluated.

Question 2: What activities have been developed or implemented by the Centers for Disease Control (CDC) to educate the public, prevent the continuation or decrease the incidence of domestic violence?

CDC was appropriated \$7.3 million in fiscal year 1994 to undertake a campaign to prevent violence against women. This campaign will identify effective measures for reducing the threat that women face of being physically abused or sexually assaulted by partners, acquaintances, and strangers.

Activities developed for the campaign are directed toward achieving five broad goals:

- Describing and tracking the problem. CDC will develop monitoring systems that will tell us how often violence against women occurs, which women face the greatest risk, and whether the problem is improving or worsening over time at national or local levels.
- Increasing our knowledge of the causes and consequences. CDC will support prevention-oriented research that will lead to greater knowledge of modifiable factors associated with violence against women and the development of new prevention strategies.
- Demonstrating and evaluating ways to prevent violence against women. CDC will undertake activities to determine how effective specific interventions are in preventing violence against women and how to combine specific interventions into effective programs.
- Supporting a national communications effort. The communications activity includes education and training of health care workers to identify and refer victims of family and intimate violence. It also includes a public awareness to bring to recognition that family and intimate violence is unacceptable and that people can take steps to prevent it.
- Fostering a nationwide network of prevention and support services. CDC will support private/public partnerships, coalitions composed of national organizations, and support within State and local health departments.

CDC is working to achieve these five goals over the next five years, thereby working toward a national program.

Question 3: Do your activities seek to address any form of violence except that which may occur between spouses or intimates?

Yes, CDC's efforts in preventing family and intimate violence have the potential to decrease other forms of violence, such as youth or stranger violence, by intervening in the cycle of violence. Research into the cycle of violence within the family has shown that children who are physically abused or neglected are more likely than others to grow up to abuse their own children. Abused children as well as children who witness parental violence are also likely to use physical violence against others when they get older. As interpersonal violence becomes more prevalent, increasingly larger numbers of children are likely to witness violence first-hand in public. This exposure may also increase the likelihood of violent behavior.

Because exposure to violence in the family is a pivotal influence on the transmission of violence across generations, public health is giving a high priority to the prevention of violence among family members and intimates. Violence is a learned behavior and older generations influence the knowledge, attitudes, and behavior of younger generations. We should be able to intervene at various points in the generation cycle to change knowledge, attitudes, and behavior conducive to violence.

Intervention early in life may prevent many different types of violence. The same principles of nonviolence that may keep individuals from resorting to violence when they are young may prevent domestic violence after they marry, child abuse after the birth of their children, and elder abuse when their parents become old.

CDC's comprehensive initiative to prevent violence against women is focused on preventing violence against adolescents and adult women (ages 12-34) that occurs in the context of families or intimate relationships. Activities are focused on traditional public health activities including surveillance, identification of risk factors, community demonstration projects, strengthening the States' ability to respond to this problem (i.e., capacity building), supporting a national network of public and private organizations dealing with this issue, and communication activities that include public information and training. CDC's family and intimate violence initiative is part of its overall violence prevention program.

CDC also conducts efforts specifically designed to prevent youth violence. For example, we support sixteen community-based demonstration projects to determine what works in preventing violence to and by youth.

Question 4: In addition to the physical manifestation of domestic violence, do any of your activities seek to address the psychological manifestations of domestic violence?

Violence against women, because of its intimate and personal nature, is a difficult problem to study. Consequently, much remains unknown about the factors that increase or decrease the likelihood that men will behave violently towards women, the factors that endanger women or protects them from violence, and the physical and emotional consequences of such violence for women and their children.

CDC is interested in understanding the full magnitude of both physical and psychological abuse. Our program, with its focus in primary prevention, will address both the physical and psychological consequences of domestic violence. In our efforts to quantify the problem, we attempt to address all health outcomes; including depression, alcohol abuse, and substance abuse. Battering often includes psychological damage, in addition to physical trauma. The National Institute of Mental Health (NIMH), our partner at the U.S. Public Health Service, studies post traumatic stress disorder among victims of domestic violence. This critical research will help enhance our knowledge of the serious health outcomes of women who are intimidated, threatened, or abused psychologically by a partner or intimate acquaintance.

Question 5: What interaction have you had with the Surgeon General and the Public Health Service in seeking to educate and train health care workers to identify and refer victims of violence?

With our partners in the U.S. Public Health Service and the Office of the Surgeon General, CDC works to fulfill the goals of the national health objectives for the year 2000. One of these objectives is to extend protocols for routine identification, treatment, and referral of suicide attempters, victims of sexual assault, and victims of spouse, elder, and child abuse to at least 90 percent of hospital emergency departments.

Through our family and intimate violence initiative, CDC is focusing on achieving this objective through the surveillance and evaluation of existing protocols, and development of model guidelines for hospitals to adopt in implementing standard protocols. In helping us meet this goal, the Joint Commission on the Accreditation of Health Care Organizations instituted a requirement in 1992 that all emergency departments and ambulatory care facilities have written policies and procedures to guide the identification and care of victims of domestic violence.

Question 6: Have you encountered any resistance or apathy from the health care community in your effort to educate and train health care workers to identify and refer victims of family and intimate violence?

There has been some difficulty in moving domestic violence ahead in a profession which has an overloaded agenda. In response, CDC has entered into contracts to evaluate two programs for training health care providers in the identification, referral, and treatment of victims of family and intimate violence to be evaluated this year by CDC. A medical school training program at U.C.L.A. and a hospital-based training program in Minnesota will be evaluated. Evaluation of education and training for health care providers may also occur through our extramural research grants, State and multi-faceted community-based cooperative agreements.

Further, CDC has a good working relationship and has co-sponsored the "Conference on Family Violence: Health and Justice" with the American Medical Association (AMA) which was held in Washington, D.C., on March 11, 1994.

Mr. TOWNS. Let me thank you for your statement, and I agree with you that it is going to require working together to bring about a solution to the problem. You mentioned in your written testimony that the epidemic proportion of domestic violence we are experiencing did not happen overnight, did not happen right away. I agree with that.

What kind of timeframe do you think is reasonable for us to see a decrease in women seeking services because of injuries caused by domestic violence or assault?

Dr. ROSENBERG. Well, I am not sure we should expect an increase in women seeking services. What I would like to see is a decrease in women seeking services.

Mr. TOWNS. Did I say increase? I meant decrease.

Dr. ROSENBERG. Actually, whichever you said makes sense, though. I think that there are not adequate services out there right now. We need more shelters. Women need a place that is safe. They need a place where they can live, and they can live with their children together, and right now many, many women across the country don't have that. So right now we don't have enough services.

We need more, and we need more information about which services work and which ones make a difference. How do you reach the doctors that Dr. McAfee was talking about? How do you get them not just to come to a lecture, but how do you get them to change what they do? So we do need to do better and we do need more women to be recognized, we need more women to feel they can speak up, and they can seek services, so I would say, first, there should be an increase in the women seeking services. After that, though, I hope that our efforts at prevention, starting with kids who are very young, teaching them how to behave, teaching them at intermediate school 302 in your community, where there is a Youth Violence Prevention Program, teaching them that violence is not the way, not the way inside the family or outside the family, will result eventually in a decrease in women seeking services.

As you can see it is going to be hard to make sense out of those numbers, but in part that is why this program was started, so we can get the numbers and make sense out of them for you.

Mr. TOWNS. At this time I yield to Congressman Schiff for any questions the Congressman might have.

Mr. SCHIFF. Just very briefly, Mr. Chairman. Dr. Rosenberg, the subject matter, of course, is domestic violence. In your judgment, from your position, is this a problem that has grown worse over the last 25 years or has it grown more reported over the last 25 years on a number or percentage of occurrences that would remain relatively constant or both?

Dr. ROSENBERG. I don't know. I don't know, and I don't think anyone does, in part, because we don't really have good information. It is very important to find out. There were a couple of national polls that tried to look at the problem to see whether it is increasing or decreasing.

The third in a series of surveys actually found fewer people reporting domestic violence, but it wasn't clear after that whether there really was a decrease in domestic violence or whether men

were just learning that they shouldn't say that they beat their wives.

If there is a real decrease it is good, but we need better data to even answer your question if it is increasing or decreasing. I think the attention that is being brought to the question is increasing, and I think more women are starting to feel safe to talk about it and more health care professionals are talking about it, but we don't know if it is really increasing or decreasing.

The problem with not knowing whether it is increasing or decreasing is that we don't know if what we are doing works, and to be able to find out if it works, we have to be able to say whether it is going down.

Mr. SCHIFF. Well, briefly, do you have an opinion—if you formed a conclusion, what, in your conclusion, would be, say, the top two or three things that do work?

Dr. ROSENBERG. Well, I think we have several things that we think work. One is we know that there is a cycle of violence, and we know that intervening very early with women when they are pregnant and counseling them and visiting them at their home can prevent child abuse.

Child abuse leads to an increase in young people who actually perpetrate violence and commit violence later on. Nurse home visitors can prevent child abuse and prevent subsequent domestic violence. We are talking now about primary prevention, preventing it in the first place. You can intervene later in the cycle by providing shelters for battered women, a place to go, a safe place, a place to begin to understand what is happening to you and make changes in your life.

We think that works, but we need to answer questions about what kind of shelters work best, how do you reach women that might otherwise not know about them? How do you reach women who are also abusing drugs or alcohol as a consequence of being battered?

Right now, a lot of shelters won't accept women with alcohol or drug problems. How do you reach them? We need to take what we think works here and improve it. I think there are a number of things that work. We can even start to work with men who are the batterers, and I think they need to be the subject of a lot of intensive investigation, but there are some programs that seem to be very promising.

Sometimes instead of sending them to jail, we are sending them to a program where they have to go every single week to learn to change their attitudes, to admit and recognize what they are doing. Some of these programs show some very promising results. We are trying to expand the rate at which we learn to answer this question, what works and how to do it.

Mr. SCHIFF. Thank you very much, doctor. I yield back, Mr. Chairman.

Mr. TOWNS. Let me just make a comment or observation here. I want to make certain that I understand what you are saying. You are stressing in terms of women and treatment for women. I was just thinking, I hope we are not making the mistake here that we made with teenage pregnancy, that we dealt just with the women, just with the young ladies, but it takes two to tango, and we should

have been dealing with the young boys as well, so are we making a mistake here when we keep emphasizing women?

What are we doing with the men? They are part of this problem, too, and I didn't hear that, Dr. Rosenberg.

Dr. ROSENBERG. I couldn't have said it as well as you, Mr. Chairman. They are absolutely important, they are very, very important. I think that they play a critical role. This last program that I just mentioned, for example, men stopping violence, it is a program directed at men who are batterers. They have to change, not the women who leave. The men have to change. The boys have to learn at IS 302, the programs are focused primarily on boys who are the perpetrators of violence as youth.

You are absolutely right. The men play a critical role, and I agree, it is not until men take responsibility for their actions, and it is not until men take responsibility for what other men do that we will be able to really change the problem.

Mr. TOWNS. Thank you very much. Appreciate your testimony. Look forward to working with you as well. Thank you, Dr. Rosenberg.

Dr. ROSENBERG. Thank you.

Mr. TOWNS. Our next witnesses are people who are on the front lines of domestic violence. For them, this is not an issue, it is reality. Miss Nichols, executive director of the House of Ruth, a shelter for battered women; Jane Doe, who survived and escaped an abusive domestic situation; Miss Tate, with the District Attorney's Office of Savannah, GA, and Mrs. Soler, executive director of the Family Violence Prevention Fund. So why don't we start with you, Miss Tate.

STATEMENT OF KIM M. TATE, OFFICE OF THE DISTRICT ATTORNEY, SAVANNAH, GA

Ms. TATE. Good morning. My name is Kim Tate. I am an assistant district attorney from Savannah, GA, and I have been specializing in the prosecution of domestic violence cases for about 2 years now. I appreciate the opportunity that you have given me to speak with you today. The letter that I received had two questions on it, and the subcommittee's first question asked that while most people consider domestic violence a criminal justice issue, can noncriminal preventive actions be used to address domestic violence.

First, we should acknowledge that it was not many years ago that the general public did not see family violence as a criminal justice issue nor did most police, prosecutors or judges within the system. Family violence was, until recent years, viewed as a private issue between intimates. But as the committee has noted, the public, as well as the criminal justice system, have accepted the criminal aspect of family violence. In some communities like Savannah, this happened years ago, while in others it began last June with the arrest of a celebrity.

However, it has been determined by Savannah's domestic violence committee, as it has been recognized across the country, that the criminal justice system cannot solve the problem of family violence alone. The system was not designed for the arrest, prosecution, and sentencing of defendants whose victims do not want them arrested, prosecuted or sent to jail.

To ask that the criminal justice system alone solve the problem of domestic violence is to ask that a system designed to be punitive should accomplish remediation, that a system designed for reaction should effect proactive purposes, that a system designed to focus on the accused should be made to serve the victim, and that a prosecution with the highest burden of proof in the world shall be capable of infinite flexibility, and that all this should be accomplished in the context of misdemeanor statutes in which jurisdiction is typically limited to 12 months.

Nonetheless, at the demand of victim advocates, the criminal justice system has adapted to handle these cases through laws which allow warrantless misdemeanor arrests and mandatory arrests through policies to prosecute without the participation of the victim and prosecutors who specialize in domestic violence cases, and through special court dockets for family violence cases and judges who handle these same dockets each week.

In order to accomplish our goal of treating domestic violence cases as any other assault and battery case as prosecutors, except for the additional factor of the ongoing safety issue with the victim, we must discover new avenues which invite more victims to follow through with the cases once an arrest is made.

I have spoken with prosecutors across the State of Georgia about the necessity of having a specialized prosecutor on domestic violence in every office, and about the special training that that prosecutor must go through and the additional duties that that person must take on.

I have also talked to them about how to prosecute cases without using the victim as a witness or in a case where a victim will be your hostile witness, but as prosecutors develop techniques for handling these cases, other community organizations must follow. Thus, the answer is, yes, noncriminal preventive actions can and should be used to address the overwhelming problem of domestic violence in our communities.

In Savannah, we are encouraged by the CDC's initiative, and, in fact, we have applied to receive grant funds to extend and improve current services offered to the public. Once Savannah's domestic violence committee established protocols for all agencies involved with the criminal justice system, it then launched a program of community awareness and training.

Earlier this year our training committee identified the medical profession as the largest gap in our community-based preventive system, and this leads to the subcommittee's second question, which was to provide information about Savannah's approach to involve the medical profession in our fight to end domestic violence in our community.

In August, our domestic violence committee conducted round table discussions with doctors, nurses, social workers, and administrators at a local hospital. They identified training as being a very important issue for them in the domestic violence field. This coincides with articles written by health care professionals that cite the lack of training as being the largest barrier to their involvement with this issue. Shall I go on?

[The prepared statement of Ms. Tate follows:]



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*Testimony of Kim M. Tate, Office of the District Attorney,
Savannah, Georgia
Subcommittee on Human Resources and Intergovernmental Relations
October 5, 1994*

The Subcommittee's first question asks that while most people consider domestic violence a criminal justice issue, can non-criminal preventative actions be used to address domestic violence?

First, we should acknowledge that it was not many years ago that the general public did not see family violence as a criminal justice issue, nor did most police, prosecutors, and judges within the system. Family violence was, until recent years, viewed as a private issue between intimates.

As the committee has noted, the public, as well as the criminal justice system, have accepted the criminal aspect of family violence. In some communities like Savannah, this happened years ago, while in others, the change began as recently as June with the arrest of a celebrity.

However, it has been determined by Savannah's Domestic Violence Committee, as it is being recognized across the country, that the criminal justice system cannot solve the problem of family violence alone. The system was not designed for the arrest, prosecution, and sentencing of defendants whose victims do not want them arrested, prosecuted, or sent to jail.

To ask that the criminal justice system alone solve the problem of domestic violence is to ask that a system designed to be punitive should accomplish remediation; that a system designed for reaction should effect proactive purposes; that a system which focuses on the accused should be made to serve the victim; that a system which presumes cooperative witnesses should function effectively in spite of hostile witnesses; that a prosecution which carries the heaviest burden of proof in the world should be capable of nearly infinite flexibility; and that all this should be accomplished in the context of misdemeanor statutes, in which jurisdiction is typically limited to twelve months.

Nonetheless, at the demand of victim advocates, the criminal justice system has adapted to handle these cases through laws which allow warrantless misdemeanor arrests and mandatory arrests, through policies to prosecute without the victim's participation and prosecutors who specialize in family violence cases, and

through special court dockets for family violence cases and judges who handle the same domestic violence calendars each week.

In order to accomplish our goal of treating domestic violence cases as any other assault and battery prosecution (with additional concern for the on-going safety of the victims), we must discover new avenues which invite more victims to follow through with the cases once an arrest is made. I have spoken with prosecutors across the State of Georgia about the necessity of a specialized prosecutor in each office to handle domestic violence cases, the additional duties and training that that attorney must undertake, and the methods for prosecuting cases without the victim or with a recanting victim.

As prosecutors develop techniques for handling these cases, other community organizations must follow. Thus, the answer is Yes; non-criminal preventative actions can and should be used to address the overwhelming problem of domestic violence in our communities. In Savannah, we are encouraged by the Centers for Disease Control's initiative and, in fact, have applied to receive grant funds to extend and improve current services offered to the public.

Once Savannah's Domestic Violence Committee established protocols for all agencies involved with the criminal justice system, it launched a program of community awareness and training. Earlier this year, our training committee identified the medical profession as the largest gap in our community-based preventative system.

This leads us to the Subcommittee's second question, which was to provide information about Savannah's approach to involve the medical profession in our fight to end domestic violence in our community.

In August, our Domestic Violence Committee conducted roundtable discussions with doctors, nurses, social workers, and administrators at a local hospital. Our purpose was to make the health care workers aware of our function as a Committee and to determine what the Committee could do, if anything, to involve these professionals in our awareness and training agenda. The response was overwhelming; the medical representatives cited domestic violence training as a priority.

Consequently, the Committee will be hosting a training seminar for the medical community of southeast Georgia next week regarding awareness, protocol, and referrals. Articles written by health care professionals cite lack of training as the primary barrier to the group's involvement with domestic violence. The authors have recognized that the medical community and the criminal justice system are the most effective places for intervention.

For victims who either plan to stay with their abusive partners and hope to end the violence or who must take flight to escape the violence, the criminal justice system may not always be the best alternative. However, it presently appears to be one of the only alternatives.

Yet the American Medical Association reports that 80% of patients would tell their doctors about abuse before they would

tell police or clergy. A recent study, funded by a Centers for Disease Control grant, found that twice as many women will report abuse when asked personally by their doctors, as opposed to being asked in a standard intake form. To allow medical professionals to have no obligation in this crisis is to allow an epidemic of injuries to go untreated.

This country typically takes on with a vengeance what it believes affects us all. The Centers for Disease Control grant funds are badly needed to address domestic violence and to make the public aware of what the violence is doing to all of us. If we, as a nation, have the inclination to take on the cause of our neighbors' cigarette smoke because it is killing us, certainly we cannot ignore our neighbors' abuse of their spouses, how it affects their children, and how those children will continue to contribute to society the violence found in public schools and on public streets.

In Savannah, we intend to stop the violence--first in our homes, before it carries into the streets and affects us all. This can only be accomplished with a comprehensive community-wide approach which includes the medical profession. The Centers for Disease Control's domestic violence initiative will help communities achieve that goal.

The authors have recognized that the medical community and the criminal justice system are the most effective places for intervention. Consequently, the Committee will be hosting a training seminar for the medical community of southeast Georgia next week regarding awareness, protocol, and referrals.

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Medical Aspects of Domestic Violence

THURSDAY, OCTOBER 13, 1994

MEMORIAL MEDICAL CENTER
AUDITORIUM

SAVANNAH, GEORGIA

COURSE OBJECTIVES

- Enhance awareness of family violence as a medical and public health problem in the United States.
- Provide information on the incidence of domestic violence and its consequences, including the burden on the healthcare system from potentially preventable injuries.
- Provide information on diagnostic markers of domestic violence, treatment guidelines, and protocols.
- Present an overview of some of the key legal aspects of domestic violence that physicians and other healthcare professionals should be aware of.
- Provide information on referral systems for care of individuals involved in domestic violence.

CONTINUING MEDICAL EDUCATION CREDIT

Memorial Medical Center is accredited by the Medical Association of Georgia to sponsor continuing medical education for physicians. Memorial Medical Center designates this course as approved for 3.5 hours in Category I of the Physicians Recognition Award of the American Medical Association.

CEU credits for social workers are available through the Clinical Social Workers Association. There is a \$5 fee for non-members.

MEDICAL ASPECTS OF DOMESTIC VIOLENCE

OCTOBER 13, 1994

PROGRAM SCHEDULE

- 11:45 Registration & Lunch
- 12:15 Incidence and Consequences of Family Violence within the United States
Anne Roise
- 1:00 Medical Aspects of Domestic Violence
Richard F. Jones III, MD
- 2:00 Break
- 2:15 Medical and Legal Issues Involving Domestic Violence
Sarah Buel, JD
- 3:00 Domestic Violence Referral Systems in the Savannah Area
Panel
- 3:45 Summary and Discussion
- 4:00 Adjourn

SPONSORS

This program is sponsored by:

DOMESTIC VIOLENCE
COMMITTEE OF SAVANNAH

CHATHAM COUNTY AND THE CRIME CONTROL
COLLABORATIVE OF CHATHAM COUNTY
in conjunction with
MEMORIAL MEDICAL CENTER

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RICHARD F. JONES III, MD

Member of the steering committee for the AMA Domestic Violence Campaign, immediate past president, American College of Obstetricians and Gynecologists. Dr. Jones regularly lectures and publishes on the topic of domestic violence, including appearances on nationally televised programs. Dr. Jones is in private practice of obstetrics and gynecology in Hartford, CT, and is the chairman of the medical staff council at Hartford Hospital.

SARAH M. BUEL, JD

Director, Domestic Violence Unit, Suffolk County District Attorney's office, Boston, MA. Member of National Association of Counsel for Children, Massachusetts Academy of Trial Attorneys, American and Massachusetts Bar Associations, and Women's Bar Association of Massachusetts.

ANNE ROISE

Executive director, Crime Control Collaborative

PANEL MEMBERS

Ralph Bashlor, Savannah Police Department

Honorable LeRoy Burke, Judge, Recorder's Court of Savannah

Steve Fishack, Parent & Child

Gail Reese, SAFE Shelter

Chuck Itzkovitz, Hunter Army Air Field Social Work Service

Helen Smith, Victim Witness Assistance Program

Kim Tate, District Attorney's office

Ned Young, Professional Correction Services, Inc.

Registration Form
MEDICAL ASPECTS OF DOMESTIC VIOLENCE
October 13, 1994

Name _____

Address City/State/Zip _____

Agency/Institution _____

Phone _____

The course fee is \$25. Please make the check payable to Memorial Medical Center - CMF and return completed registration form and check to:

JANICE NEELY, COURSE REGISTRAR
 MEMORIAL MEDICAL CENTER
 P.O. Box 23089
 SAVANNAH, GEORGIA 31403-3089

Registration Fees

The \$25 includes lunch. Registration fee is waived for employees of program sponsors.

Location

This half-day program will be held in the Memorial Medical Center Auditorium (*across from the Surgery Center entrance*) located at 4700 Waters Avenue, Savannah, GA.

Savannah is accessible by automobile via I-95 from the north or south and via I-16 from the west. It is approximately four hours southeast of Atlanta, GA.

Hotel Reservations

HOMWOOD SUITES
 5820 WHITE BLUFF ROAD
 SAVANNAH, GA 31405

Homewood Suites offers two-room suites, complimentary breakfast, evening social hour in the Lodge, swimming pool, plus other business amenities for a special Memorial Medical Center Medical Aspects of Domestic Violence Program rate of \$56 per night. This special rate is good until Oct. 7 at which time reservations will be taken on a space-available basis.

Reservations should be made directly with the hotel at 912-353-8500 or 1-800-225-5466.

For More Information

For more information, call Janice Neely, Education and Research, at 912-350-8302.

Mr. TOWNS. The light has come on. I am sure you will have an opportunity—

Mr. SCHIFF. If you have given us your statement, it will all be in the record of this hearing.

Ms. TATE. OK.

Mr. TOWNS. I am certain there will be questions that you may be able to cover.

Ms. Soler.

STATEMENT OF NANETTE FALKENBERG, ON BEHALF OF EXECUTIVE DIRECTOR, FAMILY VIOLENCE PREVENTION FUND, HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

Ms. FALKENBERG. Thank you, Chairman Towns and members of the Human Resources and Intergovernmental Relations Subcommittee for inviting me to testify today. My name is Nanette Falkenberg and I am testifying on behalf of Esta Soler, director of the Family Violence Prevention Fund, a national organization that for the past decade has been in the forefront of developing innovative responses to the epidemic of domestic violence.

The fund is committed to the creation and development of programs and policies which prevent domestic violence. Unfortunately, Esta was unable to be here today. I am a consultant with the public policy firm of Bass and Howes and work with the fund on the development of public health strategies on the issue of domestic violence.

The Family Violence Prevention Fund spent its early years training lawyers and working to improve the response of the criminal justice system to domestic violence. Through this work we have come to recognize that, while legal interventions play an important role in protecting victims of abuse, it has become increasingly clear that if we are going to end violence against women in our lifetime or for future generations, crisis intervention activities must be augmented with significant energy and resources directed at preventing domestic violence.

We have come to acknowledge that domestic violence is a public health problem, and we now devote much of our energy to addressing this issue within the health care arena. In the first part of my testimony, I will provide a general overview of the public health strategy for preventing domestic violence and will talk specifically about the role that the CDC is playing in that effort.

As you have heard, in a public health context, successful prevention rests on advancing the point of identification in response to a health care problem back to its earliest possible stage. Within the context of domestic violence, this means using the skills and resources of the health care system to identify and respond to domestic violence before it reaches the point of crisis, before it requires treatment in an emergency room setting or the intervention of the criminal justice system.

The health impact of domestic violence has been well-documented here this morning, and I will not repeat those stories. However, I do want to say that in a study of emergency rooms in California, the fund found real gaps in emergency health care providers practices for identifying and treating those victims of domestic violence. Most providers are not prepared to identify, treat or refer

victims of domestic violence beyond the treatment of their symptomatic injuries.

Our growing understanding of the health consequences of domestic violence for women, their families, and the health care system has led the fund to launch a national health initiative on domestic violence. This initiative is developing and evaluating programs to assist health care providers in addressing domestic violence.

In addition, the fund is designated by the Department of Health and Human Services as a special issue resource center for health. Within this capacity we are providing national leadership in the area of improving the health care response to domestic violence.

As you have heard this morning, in addition to its work with community service providers, the Family Violence Prevention Fund is working with the Ad Council to launch a ground-breaking national prevention campaign with the theme "There's No Excuse For Domestic Violence," and we have enclosed a copy of one of our ads with our testimony.

The campaign is designed to achieve long-term cultural change by making battering unacceptable in our society. It is designed to raise public awareness of the problem and direct concerned citizens to community programs that are working to prevent family violence. Its goal is to make Americans intolerant of domestic violence, just as they have become intolerant of drunk driving. The fund is also an active participant in the public policy arena around domestic violence.

Last year, we identified the elements of a health care strategy to prevent and treat domestic violence within a reformed health care system. The problems of domestic violence infuse every level of our health care delivery system and require a comprehensive approach. Although Federal legislation on health care reform will not move forward this year, the elements involved are still critical pieces of a health care response to domestic violence.

These elements would incorporate screening for victims of domestic violence as a part of routine preventive and primary care, the training of health care providers on domestic violence, the development and implementation of training curricula on domestic violence in health professional schools, and the establishment of partnerships between State and local public health officials and domestic violence service providers which can serve as the basis for a broad range of prevention activities in communities across the country.

I have elaborated on these points in my prepared testimony and will be happy to answer any questions. I just want to say a few words about the CDC initiative. The Family Violence Prevention Fund has worked with Members of Congress and officials of the CDC to create the Violence Against Women Program at the national Center for Injury Control and Prevention.

It is encouraging to us that NCICP has expanded its view of injury prevention to encompass this innovative program and is grappling with the new challenges it presents. While strategies to prevent domestic violence injuries are necessarily more complicated than those to, for example, prevent bicycle accidents—

Mr. TOWNS. I hate to interrupt you.

Ms. FALKENBERG. I am sorry, I missed the red light. I will summarize in one sentence by saying while we applaud the CDC's efforts and are looking forward to working with them, we hope that the next stage of efforts will focus heavily on programs which directly teach us how to prevent domestic violence at an early phase at the community-based level and not focus exclusively on studying the problem at the crisis phase. I thank you.

[The prepared statement of Ms. Falkenberg follows:]



FAMILY VIOLENCE PREVENTION FUND

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Esta Soler

Testimony of

Esta Soler

Executive Director

Family Violence Prevention Fund

Before the

HOUSE OF REPRESENTATIVES

Government Operations Committee

Subcommittee on Human Resources and Intergovernmental Relations

October 5, 1994

Building One, Suite 200, 1001 Potrero Avenue, San Francisco, CA 94110 • (415) 821-4553 • FAX (415) 824-3873

*Affiliations listed for identification purposes only.

Thank you Chairman Towns and members of the Human Resources and Intergovernmental Relations Subcommittee for inviting me to testify today. My name is Esta Soler, and I am the Director of the Family Violence Prevention Fund, a national organization that for the past decade has been in the forefront of developing innovative responses to the epidemic of domestic violence. The Fund is committed to the creation and development of programs and policies which prevent domestic violence.

The Family Violence Prevention Fund spent its early years training lawyers and working to improve the response of the criminal justice system to domestic violence. Through this work, we have come to recognize that, while legal interventions play an important role in protecting victims of abuse, significant progress toward reducing the incidence of domestic violence rests on our learning how to prevent violence against women. It has become increasingly clear that if we are going to end violence against women in our lifetime or for future generations, crisis intervention activities must be augmented with significant energy and resources directed at preventing domestic violence. We have come to acknowledge that domestic violence is a public health problem, and we now devote much of our energy to addressing this issue in the health care arena.

In the first part of this testimony, I will provide a general overview of the public health strategy for preventing domestic violence, and then I will talk specifically about the role that the Centers for Disease Control and Prevention (CDC) is playing in that effort.

Domestic Violence as a Public Health Problem

From a public health perspective, prevention is built on the concept of moving the point of identification and response to a health care problem back to the earliest possible stage. In the context of domestic violence, this would mean using the skills and resources of the health care system to identify and respond to domestic violence before it reaches the point of requiring treatment in an emergency room setting.

Violence against women takes a tremendous toll on our public health system. Battering is a leading cause of injury to women, and each year more than a million women seek medical attention because of it. Women who have been battered or sexually assaulted utilize the health care system at much higher rates than non-abused women, for a variety of health problems, including repeated injuries, stress-related disorders, depression, and other physical and mental illnesses. Pregnant women are at special risk of battering, which increases the risk of premature, low birthweight, or stillborn babies. However, in a study of emergency rooms in California, the Fund found real gaps in emergency health care providers' practices for identifying and treating victims of domestic violence. The results of this survey revealed that most providers are not prepared to identify, treat, or refer victims of domestic violence, beyond treatment of their symptomatic injuries. It is clear that health care providers are ill-equipped to recognize and treat these health care problems.

Our growing understanding of the consequences of domestic violence for women, their families and the health care system led the Fund to launch a National Health Initiative on Domestic Violence. Under the guidance of a National Advisory Committee made up of experts from major health and domestic violence organizations, this Initiative is developing and evaluating programs to assist health care providers in addressing domestic violence. In addition, the Fund has been designated by the Department of Health & Human Services as a Special Interest Research Center for Health. In this capacity, we are providing national leadership in the area of improving health care response to domestic violence. As part of this effort, the Fund is collaborating with the San Francisco-based Trauma Foundation to develop a comprehensive resource library that provides domestic violence and health care professionals with information packets, reports, journal articles, treatment protocols and training curricula on strengthening the health care response to domestic violence.

In addition to its work with community service providers, the Family Violence Prevention Fund with the Ad Council has launched a groundbreaking national prevention campaign with the theme **THERE'S NO EXCUSE FOR DOMESTIC VIOLENCE** (a copy of one of the ads is attached). This campaign is designed to achieve long-term cultural change by making battering unacceptable in our society. It will raise public awareness of the problem and direct concerned citizens to community programs which are working to prevent family violence. Its goal is to make Americans intolerant of domestic violence, just as they have become intolerant of drunk driving.

The Fund is also an active participant in the public policy arena around domestic violence. Last year, we identified the elements of a health care strategy to prevent and treat domestic violence in a reformed health care system. The problems of domestic violence infuse every level of our health care delivery system and require a comprehensive approach. Although federal legislation on health care reform is not moving forward this year, these elements are still critical pieces of the health care response to domestic violence.

An appropriate public health response to domestic violence will incorporate:

- screening for victims of domestic violence
- training of health care providers on domestic violence
- the development and implementation of training curricula on domestic violence for health professions' schools, and
- the establishment of partnerships between state and local public health officials and domestic violence service providers which can serve as the basis for a broad range of prevention activities in communities throughout the country.

Screening. Often times health care providers are the first, and sometimes the only, professionals who see a battered woman's injuries. It is undisputed that early recognition and intervention can significantly reduce the morbidity and mortality that results from violence in the home. Yet, often the abuse is not recognized or acknowledged by the providers who treat victims of domestic violence. As a result, victims are not supported by their health care providers, nor are they referred to the advocacy or social services that could help them.

Although there are written and verbal screening tools to facilitate the identification of victims of domestic violence, the practice of routine screening by health care professionals is still uncommon. Providers must be encouraged to use these tools which take the form of questions inserted in the written medical histories patients complete during routine clinician visits and verbal questions providers ask of all patients to detect the presence of violence in their current relationships.

Training of health care providers. As with any other public health problem, in order to be able to treat victims of domestic violence effectively, health care providers must be educated about the problem and trained in the appropriate medical response. Studies suggest that health care providers identify as few as one victim in 20. A survey by the Commonwealth Fund found that 92 percent of the women battered last year by an intimate partner in the United States did not discuss the abuse with their physician.

Physicians frequently treat the injuries battered women present only symptomatically, and fail to recognize or acknowledge abuse as the cause. No physician ever intends to discharge a patient with a preventable life-threatening condition without addressing steps for prevention. However, most battered women who seek medical attention are sent home to the unsafe situation that caused their injury in the first place because their physicians lack the training to identify them or the skills to fully document their injuries and intervene on their behalf.

A health care provider who does not identify a victim of domestic violence not only misses an opportunity to intervene on her behalf and interrupt the cycle of violence, but also fails to document the true source of her injuries. Such documentation becomes critically important should she wish to press criminal charges against her abuser at a later date.

Training curricula. As Congressman Wyden has told you, we are missing a very important opportunity by not training health care professionals while they are still in school about how to prevent domestic violence. Physicians learn in school and in practice about the importance of screening for the presence of serious illnesses or conditions including, high cholesterol, diabetes, obesity, smoking, unsafe sexual practices, and breast and cervical cancer. However, medical school curricula do not typically include course work and

training on domestic violence screening, identification and assessment, treatment, and referral.

A continuum of education on domestic violence is necessary if we are to see real change in both the attitudes and behavior of health care professionals. Health care providers must receive training on the issue throughout their professional careers: this includes course work and instruction prior to matriculation; in residency programs; and during the course of private practice, hospital or clinical work. To facilitate the inclusion of this issue in professional school curricula, we need to support the development and dissemination of model training curricula for schools of medicine, osteopathic medicine, public health, mental health, nursing and training programs for physician assistants, allied health professionals, family medicine physicians, general internists, general pediatricians, geriatricians and obstetrician/gynecologists.

CDC's Role in the Prevention of Violence Against Women

The Family Violence Prevention Fund worked with members of Congress and officials at the CDC to envision and create a violence against women program at the National Center for Injury Control and Prevention (NCICP). The Fund played a central role in building support among domestic violence advocates for this program, and we are delighted that the program will be expanding. It is very exciting to us that NCICP has expanded its view of injury prevention to encompass this innovative program and is grappling with the new challenges it presents. Strategies to prevent domestic violence injuries are necessarily more complicated than those to prevent bicycle accidents, but the CDC's commitment to this program demonstrates the important understanding that many of the injuries caused by domestic violence are preventable.

As you know, the goals of the CDC's violence against women injury prevention program, as defined by the Congress, are: (1) to describe and track the problem of domestic violence; (2) to demonstrate and evaluate ways to prevent violence against women; (3) to conduct a national communication effort including education, training, and public awareness; (4) to increase knowledge of modifiable factors associated with violence against women; and (5) based on that knowledge, to develop new prevention strategies.

This was the first domestic violence, health-related federal spending ever mandated by Congress, and it has the potential to bring about significant change in the national health care response to violence against women. The Fund welcomes the addition of the skills and resources that the CDC has brought to the effort to prevent injuries caused by domestic violence. We believe that this program provides an ideal opportunity to explore and expand public health initiatives for the prevention of domestic violence.

The Fund believes that this public health strategy offers the greatest hope for preventing violence against women. We are encouraged by the level of interest at the agency and would very much like to work with CDC officials on the strategies outlined above, as well as on other initiatives. We applaud the first efforts of the CDC under this program. These initial dollars spent

to collect much needed epidemiological data will bring a strong return for the investment. At the same time, we must be certain that, as we start to implement a public health approach to domestic violence, we do not expend all of our resources on understanding which *interventions* help at the point of crisis without giving adequate consideration to *prevention*.

It is the belief of the Family Violence Prevention Fund that attempts to prevent and control injuries caused by domestic violence will have the most impact when they move beyond quantifying what works and what doesn't to work closely with community service providers and to support prevention efforts at the community level. The Fund encourages the CDC in the future and with further funding to look to prevention models which have galvanized strong community involvement. The successes of anti-smoking, drunk driving, and AIDS prevention campaigns have come where community-based education has led to community involvement in solving the problem. We look forward to working with the agency in identifying and developing programs of this nature that are directed against domestic violence.

The first step in this direction has already been taken. The Fund is working in collaboration with CDC on several elements of the program, and the agency's budget for next year specifically includes funding for community-based public education efforts that will augment the national campaign launched by the Fund.

DOMESTIC VIOLENCE CAMPAIGN

A public service campaign



From
Family Violence Prevention Fund
 383 Rhode Island Street, Suite 304
 San Francisco, CA 94103-5133



"NEIGHBORS" :60

Also available in :30 length



SOUNDS OF VIOLENT
 DOMESTIC FIGHT OVERHEAD
 (SFX: CRASH)



(SFX: WOMAN CRIES)



(SFX: BANGING)
 (WOMAN SCREAMS)



(SFX: WOMAN CRIES)



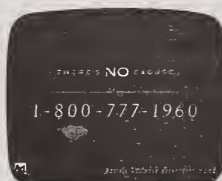
(SFX: FIGHT CONTINUES)



(SFX: LIGHT CLICKS OFF)



(CRYING FADES TO SILENCE)



ANNCR VO: For information
 about how you can help stop
 domestic violence, call us.

"WEDDING" :15

Also available in :10 length



(SFX: ORGAN MUSIC & CLICK
 OF STROBE FLASH
 THROUGHOUT)



ANNCR VO: 42% of all
 murdered women are killed
 by men...



who promised to love them.



Help stop domestic violence.
 Call us.

Volunteer Advertising Agency: Altschiller Reitzfeld
 Volunteer Campaign Director: David W. Robertson, AT&T

Mr. TOWNS. Thank you very much.
Ms. Doe.

STATEMENT OF JANE DOE, HOUSE OF RUTH

Ms. DOE. Thank you. Good morning, Chairman Towns, and members of the Human Resources and Intergovernmental Relations Subcommittee. Thank you for giving me this opportunity to discuss my personal experiences regarding domestic violence. I hope that my story will highlight the need for medical personnel to take an active role in helping to stop domestic violence.

I was married to a man for 13 years who abused me both physically and emotionally. My first contact with doctors specifically for domestic violence was in 1977 when my husband fractured my skull. All that time I was still determined to make my marriage work, and everyone thought that we had the perfect marriage. So when my doctor asked me what had happened, I was so shocked and in a state of such disbelief that I made something up and said that I hit my head while getting into bed. He explored this story with me somewhat, but I couldn't bring myself to tell him what had really happened. In those days spouse abuse was simply not discussed.

Perhaps with more training and information about domestic violence, he could have helped me to discuss the matter more openly and without being inhibited by a deep sense of shame.

Five years later, in 1982, I had a baby boy and started to see the ongoing abuse in my disintegrating marriage as a threat to my child's well-being. I wanted my son to grow up in an optimal environment. I believe that a mother is so essential to a child's development and that if she is being abused, inevitably it affects the entire family, the community, and ultimately all of society.

A child grows up so quickly, and I knew that it was up to me as his mother to summon all the self-reliance I would need to act decisively and to provide my son with a loving, secure and safe home. It was vital to me that he not be subjected to or witness any abuse, physical or emotional.

About a year later my son was monitored for a potentially serious medical condition which happily resolved itself years later. While I was speaking with his pediatrician where he was initially being treated, he asked me about the impact of his condition on my well-being, and I told him that I was doing fine.

In 1983, I took my son to a female pediatrician with a specialty in this field. While she discussed the overall impact of an infant's medical crisis on the family, she helped me to also focus on the dearth of emotional and spiritual resources in my marriage. The doctor referred me to a social worker and I eventually told her about the skull fracture.

After working through a lot of denial, she helped me to acknowledge the fact that I was an abused wife, and I began to work on the healing process. Later on, I saw a psychologist who further helped me to understand the dynamics of abuse. She accentuated working on my self-esteem, and this gave me the strength and courage to leave my marriage.

While consulting with these health professionals, I was working to make sure that I had done everything humanly possible to make

my marriage work, because I was raised to believe that once one marries, it is for better or worse. When I knew that I had done everything possible and could endure no further abuse, I knew that I must take responsibility for my own and my child's well-being. These health professionals helped me to build the strength I needed to file for divorce.

While going through the divorce, I spoke with my internist to verify the date of the skull fracture. He had also treated me for a preulcerous condition, which dissipated after I left the stressful marriage. The doctor supported my decision to divorce my former husband, and that support was immensely helpful. I needed those health professionals to guide and support me through this process because I did not know that I had a way out and the right to leave that marriage. I thought that I was doomed to stay with this man forever.

As only one out of several million abused American women, I urge this body to declare domestic violence as a public health issue. With a viciousness that destroys families as devastatingly as any catastrophic disease, domestic violence must be given serious recognition and treatment by the health professional community.

I believe that the family doctor is often the closest and most trusted individual available to talk with about personal health problems. If my family doctor had been more astute in recognizing the signs of domestic violence and suggested different courses of action, perhaps my life could have been very different.

The positive interventions of health professionals who did understand the signs of domestic abuse helped me to learn and grow and most significantly they empowered me to leave an abusive marriage and to begin a new and healthier life. Thank you.

Mr. TOWNS. Thank you very, very much. There is a vote on, but what I would like to do is to hear Mrs. Nichols before going to vote. Ms. Nichols.

STATEMENT OF CHRISTEL NICHOLS, EXECUTIVE DIRECTOR, HOUSE OF RUTH, WASHINGTON, DC

Ms. NICHOLS. Thank you. Good morning, Chairman Towns and members of the Human Resources and Intergovernmental Relations Committee. Thank you for inviting me to testify on the public health implications of domestic violence. My statements support the premise that domestic violence is a major public health problem.

I am the executive director of the House of Ruth, a social service agency in Washington, DC, and we serve women and children. The House of Ruth has seven different programs, and we provide services to approximately 1,500 individuals a year. One of our programs focuses extensively on the issues and needs of families experiencing domestic violence.

One of the questions that I was asked was to provide evidence that there is a public health issue related to domestic violence. Therefore, the following summary of statistics and findings of 100 families that sought shelter services in the last 2 years at House of Ruth also supports the information that domestic violence is a public health problem. Here are some of the statistics.

One hundred percent of the women sustained repeated physical injuries such as abrasions, contusions, sprains and broken bones. Sixty percent of the women sought medical intervention more than once for physical injuries as a result of domestic violence. Seventy-five percent of the women had chronic medical problems related to the domestic violence including both somatic conditions and psychological disorders.

Seventy-five percent of the women displayed characteristics associated with individuals experiencing trauma. Forty-five percent of the women had a substance abuse problem. Seventy-five percent of the children experiencing domestic violence displayed physically aggressive behaviors. Thirty percent of these children involved in domestic violence ages 2 to 5 had developmental delays in the emotional-social behavioral areas, as supported by psychological testing.

Eighty percent of the women witnessed parental violence as a child and were also involved in multiple abusive relationships. Sixty-five percent of the women it could be assumed that there was a strong correlation between the incidence of domestic violence and decreased functioning in core indicators, such as employment, income, parenting, and self-sufficiency. Fifty percent of the women felt that her life or the lives of her children were endangered as a consequence of the domestic violence.

These findings from this sample highlight both the short-term as well as the long-term effects of domestic violence, which encompasses the individual physical and emotional safety issues as well as overall functioning. There are also the financial and societal costs associated with the violence for which I do not have data, such as the health care costs, the loss of productivity, and the correlation with street violence.

I strongly support the need for ongoing research to identify the interventions which significantly reduce the incidences of domestic violence, as well as the preventive models and methods to lower the number of future occurrences.

Most of the work to impact this issue has really been in the social service and the law enforcement fields. I encourage continued efforts in these fields. However, Richard Gelles and Murray Strauss, both prominent domestic violence researchers, contend that the high rate of domestic violence occurs because not only are there limited consequences for the perpetrator, but there are very ambivalent attitudes regarding domestic violence in our society.

The medical community has a prominent role in determining and changing attitudes and actions in American society. For example, they exercised that power in influencing how we view smoking. As a result, many of us changed our behaviors. Now, it is time for the medical community to make domestic violence a priority health issue.

Presently, doctors, nurses, and other health care personnel do not routinely consider domestic violence as a part of their treatment responsibility. This lack of awareness of many medical personnel and their reticence to deal with those very personal problems will continue until they are mandated and trained to follow a new course of action. A lack of action may also be a result of numerous factors, including attitudinal barriers. Victims of domestic

violence report to us that signs of the violence are generally ignored and information is not elicited from them about the occurrences.

I think attitudinal barriers can be overcome with policy changes, enhanced training, and an improved and extended system of interventions and resources for the victim, the abuser, and most importantly, the children.

An analogy can be made to the modifications that the medical field undertook in the identification and intervention protocols that they developed for both child abuse and sexually transmitted diseases. Both of those health issues underwent many, many changes as a result of this change in attitudes and priority.

Oftentimes, these were a result of legislative policies. Similar legislation could have a significant impact on the medical community's mandated obligation in identifying and comprehensively treating this health problem. Having nurses and doctors ask about the occurrences of violence as a part of the medical history taking encourages and supports victims to talk about the issue. Yet health care professionals need additional training to understand the dynamics and consequences of domestic violence to skillfully explore the problem.

Openly acknowledging the abuse is still generally considered taboo and humiliating to the victim. Also, the abuser typically denies, minimizes or rationalizes his or her involvement in the abuse. Through additional training and protocols, I believe changes can be made, and I am encouraged by the statements that I heard today from the medical community that they are making it a priority. However, in the front lines there is still an awful lot of work that needs to be done. Thank you.

[The prepared statement of Ms. Nichols follows:]

Statement of Christel Nichols
Executive Director of the House of Ruth
Washington DC
on the Public Health Implications
of Domestic Violence
Before the
Human Resources and Intergovernmental Relations
Subcommittee
of the
Committee on Government Operations
on October 5, 1994

Good Morning Chairman Townes and members of the Human Resources and Intergovernmental Relations Subcommittee. Thank you for inviting me to testify on the public health implications of domestic violence. My statements support the premise that domestic violence is a major public health problem. I am the Executive Director of the House of Ruth, a social service agency for women and children in Washington DC. The House of Ruth has seven different programs and provides services to approximately 1,500 individuals a year. One program focuses extensively on the issues and needs of families experiencing domestic violence.

The following summary of statistics and findings of 100 families seeking services in the last two years at House of Ruth supports the position that domestic violence poses a public health problem. Here are the findings:

1. 100% of the women sustained repeated physical injuries such as abrasions, contusions, sprains and broken bones;
2. 60% of the women sought medical intervention more than once for physical injuries as the result of domestic violence;
3. 75% of the women had chronic medical problems related to the domestic violence including both somatic conditions and psychological disorders;
4. 75% of the women displayed characteristics associated with individuals experiencing trauma (i.e. depression);
5. 45% of the women had a substance abuse problem;
6. 75% of the children experiencing domestic violence displayed physical aggressive behaviors
7. 30% of these children involved in domestic violence, ages 2 - 5 had developmental delays in the emotional-social behavioral areas;
8. 80% of the women witnessed parental violence as a child and were involved in multiple abusive relationships;

Statement of Christel Nichols
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9. In 65% of women it could be assumed that there was a strong correlation between the incidence of domestic violence and decreased functioning in core indicators such as employment, income, parenting and self-sufficiency;
10. 50% of women felt that her life and/or the lives of her children were endangered as a consequence of the domestic violence.

These findings from this sample highlight both the short term and long term effects of domestic violence, which encompass individual physical and emotional safety and overall functioning. There are also the financial and societal costs associated with domestic violence for which I do not have data, such as health care costs, the loss of productivity and the correlation with street violence.

I support the need for ongoing research to identify interventions to significantly reduce the incidences of domestic violence as well as preventive methods to lower the number of future occurrences.

Most of the work to impact this issue has been in the social service and law enforcement fields. I encourage continued efforts in those areas. However, Richard Gelles and Murray Strauss, prominent domestic violence researchers, contend that the high rate of domestic violence occurs because not only are there limited consequences for the perpetrator but there are ambivalent attitudes regarding domestic violence in our society.

The medical community has a prominent role in determining and changing attitudes and actions in American society. For example, they exercised that power in influencing how we view smoking. Many of us changed our behaviors. Now it is time for the medical community to make domestic violence a priority health issue. Presently doctors, nurses and other health care personnel do not routinely consider domestic violence as a part of their treatment responsibility. This lack of awareness on many medical personnel and their reticent to deal with those very personal problems will continue until they are mandated to follow a new course of action. A lack of action may also be a result of numerous factors including attitudinal barriers to intervention. Victims of domestic violence report to us that signs of the violence are generally ignored and information is not elicited from them about the occurrences.

Statement of Christel Nichols
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I think attitudinal barriers can be overcome with policy changes, enhanced training and an improved and extended system of interventions and resources for the victim, the abuser and the children.

An analogy can be made to the modifications that the medical field undertook in the identification and intervention protocols for both child abuse and sexually transmitted disease. Those changes occurred as a result of legislated policies. Similar legislation would have a significant impact on the medical community's mandated obligation in identifying and comprehensively treating this health problem. Having nurses and doctors ask about the occurrences of violence as a part of medical history taking encourages and supports victims to talk about the abuse.

Yet health professionals need additional training to understand the dynamics and consequences of the domestic violence to skillfully explore the problem. Openly acknowledging the abuse is still generally considered taboo and humiliating to the victim. Also the abuser typically denies, minimizes or rationalizes his/her involvement in the abuse. The medical community needs training and protocols to assess the signs through observations, open communication and reduce the barriers to disclosure for the entire family including the children.

This education including sensitivity and cultural issues awareness must occur in all phases of the professional preparation for all medical personnel. Ongoing findings in professional journals and seminars including the correlated problems of child abuse, substance abuse and depression need to be integrated into the continuous development process.

In developing a range of interventions, a comprehensive approach needs to be created and implemented to incorporate social service, law enforcement and educational interventions and actions. Reducing domestic violence means changing attitudes and medical behaviors. The medical field must take a prominent position in understanding and applying methods of change. There must be a coordinated process for specialized services and resources among the various fields.

The medical community must recognize that domestic violence is intolerable and they have a significant responsibility in reducing the incidence of violence.

Mr. TOWNS. Thank you. Let me thank all of you for your testimony. There is a vote on so what we would do is take a 10-minute recess and return.

Mr. SCHIFF. Mr. Chairman, I would propose, just because, unfortunately, this is, as you know, we think the last couple days of our being in session, I would propose to waive questions and to again remind the witnesses that their entire printed statements will be part of the hearing, if they didn't complete the oral presentation.

Mr. TOWNS. Well, I think that I agree with the gentleman that there is a markup going on and that there are so many things we are trying to get in within the closing days. We will submit questions to you, and then you can answer them in writing rather than to hold you any longer.

I will tell you one of the questions I will raise will be what can we do with men. Are we doing enough in that regard? I am not hearing too much about that as I am getting testimony. It is a serious problem. We have to deal with it in more ways than one.

I think we have to do everything we can for the women and I think we should do it as fast as we possibly can. I think we should do research, but in the meantime there is a problem, and I think we should deal with the problem even while the research is going on. At the same time I think that males are involved. We have to look at what we might be able to do with them as well. I will be raising these questions with you and would appreciate in your thinking as we look to do something about it legislatively. Thank you very much for your testimony. Here again, we have a vote on.

The committee will adjourn. We have a markup on unfunded mandates. We will be back at 12:30 to continue this hearing. Thank you very, very much.

[Recess taken.]

Mr. TOWNS. Let me, again, apologize for the delay, but there are just so many things going on. The legislation that we are debating in mark-up is my bill and Mr. Schiff happened to be the other sponsor of it. It is being marked up now, and that is the reason we were delayed. We would like to continue this hearing because we want to make a record, which can be read by all the Members of Congress, and the public. We would like to continue the hearing at this time.

Our witnesses on panel four represent the medical profession—Dr. Jacquelyn Campbell wears many hats. She is a nurse, a professor, a researcher and a Chair of the American Academy of Nursing Expert Panel on Violence, so she is a multifaceted woman.

Dr. Bruce MacLeod is the director of the Department of Emergency Medicine at Mercy Hospital of Pittsburgh, and Dr. Patricia Salber is an emergency room physician and a member of the board of directors of the American College of Emergency Physicians, and Dr. Lisa Goodman is a psychologist and is cochair of the American Psychological Association task force on male violence against women.

Let me welcome all of you to the subcommittee and we would like for you to summarize your statements within the 5-minute period. Your entire statement will be included in the record, so feel free to summarize.

Why don't we start with you, Dr. Campbell, and then come right down the line.

**STATEMENT OF JACQUELYN C. CAMPBELL, Ph.D., R.N., F.A.A.N.,
CHAIR, EXPERT PANEL ON VIOLENCE, AMERICAN ACADEMY
OF NURSING, PROFESSOR, JOHN HOPKINS UNIVERSITY
SCHOOL OF NURSING**

Ms. CAMPBELL. Thank you very much, Mr. Chairman, and thank you for inviting me to testify today and for your attention to this very important problem. I will try not to repeat some of the statistics that have been given before, and they are in my written comments. However, I do want to emphasize a few of the aspects that make us convinced that domestic violence is indeed a public health problem.

It is important to realize that domestic violence is most often a pattern of coercive control of a female partner. The national victims survey indicates that women are 10 times more likely to be the victim of serious assault from intimate partners than are males. The physical violence is accompanied by a context of coercive control that also involves ongoing sexual abuse, emotional degradation, threats to the woman, the children, her family and belongings, financial control, and forced social isolation.

One of the most important health care issues is the sexual abuse. In my own research and from others, it is clear that at least 40 to 45 percent of physically battered women are also being forced into sex. Women report health problems such as increased sexually transmitted diseases, vaginal and anal tearing, urinary tract and vaginal infections, and severe pain on intercourse as a result of this violation.

They are also at increased risk for AIDS. If a woman is being forced into sex, it is obviously impossible for her to insist that he wear a condom, and the woman is not going to say, by the way, this happens to her physician or her nurse, and we have to ask directly about the forced sex issue.

Other physical health care problems that have been associated with domestic violence include premature deafness, chronic irritable bowel syndrome, chronic pain and immune system disorders. Another serious physical ramification is abuse during pregnancy. The results of one of the best studies conducted by my nursing colleagues, Doctors Judith McFarlane and Barbara Parker, was just published in *Obstetrics and Gynecology*. They found that 20 percent of pregnant adolescents and 14 percent of adult pregnant women in their study of 1,200 African-American, Hispanic, and Anglo women were being abused during pregnancy. This abuse during pregnancy was a significant risk factor for lower birth weight, low maternal weight gain, infections, anemia, smoking, and use of alcohol and drugs.

The costs of this domestic violence to the health care system are substantial, and I don't think this point has yet been made. Abused women and their children used health care services extensively and more often than other women and children in order to take care of these physical and emotional consequences.

A study conducted at Rush Presbyterian Medical Center found that the average charge for medical services provided to abused

women, children, and elders was \$1,633 per person per year. That amounts to a national annual cost of \$857.3 million.

In terms of prevention, we heard about the Family Violence Prevention Fund initiative, and this is very important. Our citizens tend to think that domestic violence is a private matter. We need to turn that around so that people accept the societal responsibility. In cross-cultural studies we find that where small communities and neighborhoods take responsibility for making sure that men don't batter women, wife beating is kept to a minimum. Churches, neighborhood organizations, workplaces, and schools all need to take on domestic violence as an issue that affects their future.

Before we address the need for primary prevention in our communities, we have to make sure that there are adequate shelters and shelter services for victims who are currently in danger. The Department of Health and Human Services estimated that 40 percent of battered women were turned away from shelters due to lack of space in 1990.

Once shelter services are assured, other prevention initiatives can begin. All programs designed to address the prevention of violence in general need to have a domestic violence prevention component. For instance, programs that address the transition to manhood and/or adulthood could have a component on gender relations and how to prevent domestic violence.

One of the most important activities would be to fund interventions with the children of abused women. We know that these children are affected by violence, their health is affected, and especially the young men are more likely to abuse their own partners when they grow up. Courts that deal with domestic violence need to have the resources to provide interventions for the children in these families as well as assuring good treatment and enforced court mandates for abusers.

To help prevent the homicides, any handguns in homes where someone has been arrested for domestic violence should be impounded, and men who have had orders of protection for domestic violence served against them should not be allowed to own handguns.

In summary, the American Nurses Association and the American Medical Association have done a great deal in the last few years to address the issue of domestic violence. We need to do a great deal more.

One of the things we need to know is what interventions work, what interventions work early, and what interventions are culturally appropriate for different cultural groups. We need research to establish that. Until we know what interventions work, physicians and nurses are unlikely to take action beyond just screening.

Again, I thank you very much for the opportunity to testify today and to say that attitudes can only be changed gradually and with systematic and sustained attention. Initiatives to prevent and counter domestic violence need to be directed to both society and the health care system. Thank you.

[The prepared statement of Dr. Campbell follows:]

Testimony before the United States House of Representatives
Committee on Government Operations
October 5, 1994

Jacquelyn C. Campbell, PhD, RN, FAAN
Chair, Expert Panel, American Academy of Nursing
Member, AMA Executive Committee on Family Violence
Anna D. Wolf Endowed Professor, Johns Hopkins University School of Nursing

It is my pleasure to testify before this committee about the extremely important issue of domestic violence. I have been working as a researcher and advocate in this field for the past 14 years and hope that I can convey to you some of my concern about the women and child affected and the potential for alleviating and preventing the problem through change in our health care response.

Domestic Violence as a Public Health Issue

Domestic violence is clearly a public health problem, in terms of mortality, of physical injury, of mental health problems, of future health problems and in terms of costs to the health care system. I will address each of these issues in turn. Domestic violence is responsible for the majority of homicides of women. Homicide is now the leading cause of death for young African American women and the seventh leading cause of premature death for women overall (DHHS, 1990). The majority of women are killed by a husband, boyfriend or ex-husband or ex-boyfriend and in approximately two thirds of those cases, there is a documented history of wife abuse before the woman was killed (Campbell, 1992; Mercy & Saltzman, 1989). Similarly, when women kill men, they almost always kill a husband, boyfriend or ex-husband or ex-boyfriend. And in the majority of those cases also, there is a documented history of wife abuse, with the male partner also far more likely to have been the first to show a weapon or strike a blow during the incident preceding the homicide.

For each committed homicide, there are many serious assaults that may have ended in death if not for the intervention of the health care system. Although the outcome of those cases is far less tragic, there is still often ongoing health problems as a result of the injury. The leading cause of both spinal cord injuries and ostomies in our inner cities is now gunshot wounds. Although these injuries far more often involve young men, when they occur to women, it is most often the result of domestic violence. The leading cause of female trauma in urban emergency departments is domestic violence, with from 10-25% of women in emergency rooms (depending on the study) being the victims of domestic violence (Goldberg & Tomlanovich, 1985; Grisso et. al., 1991; McLeer et. al., 1989). These women are more likely to return to use emergency and other health care services than other women.

It is important to realize that domestic violence is most often a pattern of coercive control of a female partner. The National Victim Survey (USDJ, 1994) indicates that women are 10 times more likely to be the victim of serious assault from intimate partners than are males. The physical violence is accompanied by a context of coercive control that also involves ongoing sexual abuse, emotional degradation, threats to the woman, the children, her family and belongings, financial control, and forced social isolation. One of the most important health care issues is the sexual abuse. In my own research and from others, it is

clear that at least 40-45% of physically battered women are also being forced into sex (Campbell & Alford, 1989). Women report health problems such as increased sexually transmitted diseases (STD's), vaginal and anal tearing, urinary tract and vaginal infections, and severe pain on intercourse as a result of this violation. They are also at increased risk for AIDS. If a woman is being forced into sex, it is obviously impossible for her to insist that he wear a condom.

Other physical health care problems that have been associated with domestic violence include premature deafness, chronic irritable bowel syndrome, chronic pain, and immune system disorders. The neurological sequelae have yet to be thoroughly investigated, but just as we know that boxers are likely to develop neurological problems over time, it makes sense that battered women will also. The continuum of domestic violence is wide, ranging from "only" occasional pushes and shoves to homicide as I mentioned. But it tends to increase in severity and frequency over time.

Another serious physical ramification is abuse during pregnancy. The results of one of the best studies conducted by my nursing colleagues Drs. Judith McFarlane and Barbara Parker was just published in *Obstetrics and Gynecology* (1994). They found that 20% of pregnant adolescents and 14% of adult women in their study of 1200 African American, Hispanic and Anglo women were being abused during that pregnancy. The Hispanic women, primarily Mexican American, were slightly but significantly less likely to be abused during pregnancy than the Anglo and African American, while the Anglo women were the most frequently and severely abused. The abused women overall were more likely to enter prenatal care late, probably related to the forced isolation I spoke of earlier. Abuse during pregnancy was a significant risk factor for lower birth weight, low maternal weight gain, infections, anemia, smoking and use of alcohol or drugs. This study is corroborated by research of my own that also showed an association with inadequate prenatal care, substance abuse and also showed an association with depression and anxiety.

The children of abused women are highly at risk to be abused, probably especially those abused during pregnancy. There is at least a 30% overlap of child abuse and wife abuse, with approximately 30% the mothers of abused children also being battered by the father. Similarly, about 30% of the children of battered women are also abused. These children are also at risk to develop school problems, stress related health problems and most importantly, the boys are seriously at risk to grown up to become more abused themselves.

Another serious health care ramification of domestic violence is the serious mental health consequences. Abused women are most likely to respond with depression yet the extent of our major health care problem of depression in women that is related to abuse has not yet been documented in large scale studies. In studies of battered women, including my own, approximate from 30-60% show significant depression (Campbell, 1989; Jaffee et. al., 1986). In addition, from 40-55% of battered women in several samples have been diagnosed with Post Traumatic Stress Disorder (PTSD). Post Traumatic Stress is a normal psychological response to trauma but can compromise functioning significantly without appropriate treatment. More

information is needed about appropriate treatment for PTSD in battered women, where the trauma is ongoing.

The costs to the health care system are substantial. Abused women and their children use health care services extensively in order to take care of these physical and emotional consequences (Bergman & Brisman, 1991). A study conducted at Rush Presbyterian Medical Center found that the average charge for medical services provided to abused women, children, and elders was \$1,633 per person per year. That amounts to a national annual cost \$857.3 million.

Prevention

The Family Violence Prevention Fund has recently initiated a national public awareness campaign to help to educate the public on this issue. These television and newsmagazine ads are timely and effective but more needs to be done. Our citizens tend to think that domestic violence is a private matter. We need to turn that around, so that people accept the societal responsibility to change our attitudes toward domestic violence. Cross cultural studies indicate that where small communities and neighborhoods take responsibility for making sure that men don't batter women, wife beating is kept to a minimum. Churches, neighborhood organizations, work places and schools all need to take on domestic violence as an issue that affects their future. Before we address the issue of primary prevention in our communities; however, we need to be sure that there are adequate shelters and shelter services for victims who are currently in danger. The Department of Health and Human Services estimated that 40% of battered women were turned away from shelters due to lack of space in 1990.

Once shelter services are assured, other prevention initiatives can begin. All programs designed to address the prevention of violence in general need to have a domestic violence prevention component. For instance, programs that address the transition to manhood and/or adulthood could have a component on gender relations and how to prevent domestic violence. One of the most important activities would be to fund interventions with the children of abused women as a group with particular needs around processing the trauma of growing up in a violent home and not learning to be violent in their own adolescent and adult intimate relationships. Peer conflict resolution programs in schools need a significant gender conflict component with attitudes of respect between young men and women fostered. Courts that deal with domestic violence need to have the resources to provide interventions for the children in these families, as well as assuring good treatment and enforced court mandates for the abusers. To help prevent the homicides, any handguns in homes where someone has been arrested for domestic violence should be impounded, and men who have had orders of protection for domestic violence served against them should not be allowed to own a handgun.

Psychological Consequences

One of the important steps that can be taken is to address the psychological consequences of abuse in our primary care systems. When women report depression and other

mental health problems, a history of childhood and adult violence experiences need to be taken. Treatment should include abuse related interventions and referrals to shelter services. School health programs need to be addressing the psychological sequelae of traumatic victimization. also. The incidence of domestic violence is sufficient to indicate screening of all adult women in health care systems for this problem. In that way, the abuse can be detected early, before the patterns have become entrenched and the injuries and emotional responses severe. Treatment for domestic violence related issues needs to be reimbursable through private and public insurance mechanisms. Shelter support group services need to be expanded across communities so that women have more access to this cost effective intervention.

Health Care System Response

The interest of the health care system in the issue of domestic violence has definitely increased in the past two years through a combination of increased research results, official attention to the problem such as inclusion in the DHHS Health People 2000 document, and mandates such as the JCAHO (Joint Commission of the Association of Hospital Organizations) requirements for domestic violence protocols and procedures. Organizational attention from the American Nurses' Association and the American Medical Association have been extremely important. There is still some resistance from physicians and nurses to providing health care system interventions to battered women, mainly in terms of time and concerns related to reimbursement. The American Nursing Association and its constituent organizations and the Nursing Network on Violence Against Women International are holding domestic violence recognition and intervention training sessions at most of their national and regional meetings. Many articles have been written in the nursing and medical journals and newsletters to alert the constituency of the importance of these problems. The Family Violence Prevention Fund is holding a national Train the Trainers Conference that is intended to improve emergency department response to abuse by providing training that hospital personnel can take back to their own staff. There are an array of new task forces and committees that are addressing the issue. Most nurses are concerned about the issue but feel frustrated because of time and role constraints, as well as stating that they need more information about appropriate interventions.

Although I cannot speak for physicians, I can say that the official response from the AMA and other state and national physician groups has been extremely positive. The AMA has provided extremely important leadership in this arena. Convincing individual physicians, especially private physicians, that there is a sufficient problem in their practice is more difficult. Most women say that they would not find it an invasion of privacy to be asked by their physician about domestic violence, but in this era of stiff competition, this is still a concern. There is also a very realistic concern that interventions, especially at various stages of abuse, have not been tested. We need more research on this subject to determine the best interventions and when they should be initiated. Time constraints are also real, and in some studies it may be more efficient for other professionals to carry out domestic violence screening and interventions. Insurance providers need to be convinced of the cost savings of early intervention. There also needs to be increased content on domestic violence in medical and nursing curricula, on licensing exams and in continuing education. Although mandates can

References

- Bachman, R. (1994). Violence Against Women (A National Crime Victimization Survey Report). U.S. Department of Justice.
- Bell, C. C. & Jenkins, E. J. (1991). Traumatic Stress in Children. Journal of Health Care for the Poor and Underserved, 2(1):175-183.
- Bergman, B. and Brisman, B. (1991). A 5-year follow-up study of 117 battered women. American Journal of Public Health, 81, 1486-1488.
- Browne, A. (1987). Battered women who kill. New York: Free Press.
- Campbell, J. C. (1992). "If I can't have you, no one can": Power and control in homicide of female partners. In J. Radford & D. Russell (eds.), Femicide: The politics of woman killing. Boston, MA: Twayne.
- Campbell, J. C. (1989). A test of two explanatory models of women's responses to battering. Nursing Research, 38, 18-24.
- Campbell, J.C. & Alford, P. The dark consequences of marital rape. American Journal of Nursing, 89, 946-949.
- Council on Scientific Affairs, American Medical Association (1992). Violence Against Women: Relevance for medical Practitioners. JAMA, 267, 3184-3189.
- Department of Health and Human Services (DHHS). (1990). Healthy people two thousand: National health promotion and disease prevention objectives. Washington, DC: DHHS.
- Grisso, J.A., Wishner, A.R., Schwarz, D.F., et al. (1991). A population-based study of injuries in inner-city women. American Journal of Epidemiology, 134, 59-68.
- Hawkins, D. F. (1993). Inequality, culture, and interpersonal violence. Health Affairs, Winter 1993:80-95.
- Jaffe, P., Wolfe, D., Wilson, S. & Zak, L. (1986). Emotional and physical health problems of battered women. Canadian Journal of Psychiatry, 31, 625-629.
- Kellermann, A. L. & Mercy, J. A. (1992). Men, women and murder: Gender-specific differences in rates of fatal violence and victimization. Journal of Trauma 33(1):1-5.
- Kerouac, S., Taggart, M.E., Lescop, J., Fortin, M.F. (1986). Dimensions of health in violent families. Health Care for Women International, 7, 413-426.

Kurz, D. & Stark E. (1988). Not-so-benign neglect: The medical response to battering, In K. Yllo & M. Bograd (Eds.). Feminist Perspectives on Wife Abuse. Newbury Park, CA: Sage Publications, Inc.

McFarlane, J., Parker, B., Soeken, K., & Bullock, L. (1992). Assessing for abuse during pregnancy: Severity and frequency of injuries and associated entry into prenatal care. Journal of the American Medical Association, 267:3176-3178.

McLear, S., Anwar, R.A., Herman, S. and Maquilling, K. (1989). Education is not enough: A systems failure in protecting battered women. Annals of Emergency Medicine, 18, 651-653.

McLoughlin, L., Lee, D. & Letelier P. (1993). Emergency department response to domestic violence - California. Morbidity and Mortality Weekly Report, 42, 617-619.

Mercy, J. A., & Saltzman, L. E. (1989). Fatal violence among spouses in the United States, 1976-85. American Journal of Public Health, 79:595-599.

Parker, B., McFarlane J. & Soeken, K. (1994). Abuse During Pregnancy: Effects on maternal complications and birth weight in adult and teenage women. Obstetrics & Gynecology, 84, 323-328.

Plichta, S. (1992). The effects of women abuse on health care utilization and health status: A literature review. Women Abuse, 2, 154-163.

Rose, K. & Saunders D. (1986). Nurses' and physicians' attitudes about women abuse: The effects of gender and professional role. Health Care for Women International, 7, 427-438.

Rosenberg, M.L., O'Carroll, P.W. and Powell, K.E. (1992). Let's be clear: Violence is a public health problem. JAMA, 267, 117-118.

Saunders, D. G. (1986). When battered women use violence: Husband-abuse or self-defense? Violence and Victims, 1:47-60.

Stark, E., Flitcraft, A. & Frazier, W. (1979). Medicine and patriarchal violence: the social construction of a private event. Int. Journal Health Serv., 9, 461-493.

Straus, M. A. & Gelles, R. J. (1990). Physical violence in American families: Risk factors and adaptations to violence in 8,145 families. New Brunswick: Transaction.

Sugg, NK & Inui, T. (1992). Primary care physicians' response to domestic violence. JAMA, 267, 3157-3160.

Voelker, R. (----). Nation begins to see family violence as public health issue. American Medical News.

Mr. TOWNS. Thank you for your testimony.
Dr. MacLeod.

STATEMENT OF BRUCE A. MACLEOD, M.D., F.A.C.E.P., CHAIRMAN, DEPARTMENT OF EMERGENCY MEDICINE, MERCY HOSPITAL OF PITTSBURGH

Dr. MACLEOD. Thank you very much. My name is Bruce MacLeod. I am a practicing emergency physician on the front lines of this very important issue. Domestic violence has been a part of our society for some time. We have now begun to recognize its myriad of presentations, its consequences, and what might be some interventions.

The syndrome of domestic violence carries societal stigmata and complex social interactions. The victims of domestic violence that I have taken care of in the emergency department are afraid, ashamed, and confused all at the same time. There are complex societal expectations which might suggest that disputes between a man and a woman are private matters, not to be discussed in public regardless of what transpires.

This reminds me of women who began to look at child abuse and some parents felt that their interaction with their children was indeed a private matter. Just as it is unacceptable to abuse a child, so too should we expect the interaction between a man and a woman to be compatible with the values of human dignity.

In the emergency department, I see the obvious effects of domestic violence, the bruises, the broken bones, the physical trauma. I also see the indirect presentations of domestic violence, women who present with somatic complaints which are coping mechanisms or manifestations of the persistent stress of their abusive environment. I also see the cycle of generational violence.

The child learns domestic violence as a method to settle interpersonal disputes. This then becomes a learned behavior which shows up in the form of child abuse, spousal abuse and other interpersonal violence. Just as child abuse is not a private matter, just as motorcycle helmets are not a private matter, domestic violence cannot be relegated to this fear of a private matter.

I continue to see women in abusive relationships with both physiological and psychological abuse who either don't recognize it or feel that it is their destiny, the hand, if you will, that has been dealt to them; that they are obligated to play out until the end.

Our commitment to human rights should extend to these women. Why has it taken us so long to recognize this epidemic of domestic violence? In the emergency departments I believe the delay is multifactorial, but with two main reasons—recognition and resources.

Recognition of domestic violence victims requires a high level of suspicion and a victim willing to ask for help. There has been some sense here today that it might be an easy process to identify the victims of domestic violence. I can assure you as a practitioner, it is very difficult. The victims can present to the health care practitioner with a wide variety of complaints beyond the obvious physical violence—headaches, nonspecific abdominal pain, cuts, bruises.

This has to be considered in the context of all the other patients that are seen that have these complaints that do not have domestic

violence. So to identify them is very challenging for the practitioner. In our emergency department we have implemented a nonjudgmental private assessment form for all women above the age of 18 which the patient completes in the privacy of the examination room.

If she answers affirmatively, the nurse or the physician can ask her if she would like help in any way, and we do this in a way that does not jeopardize her safety. The assessment form has been very important to the success in identifying domestic violence victims with nonspecific complaints or with the seemingly innocuous physical injury.

I believe that better identification will come from the institutionalization of the domestic violence issue, through protocols, assessment tools, and the like. I would like to take a moment to talk about the domestic violence program at the Mercy Hospital of Pittsburgh. The Mercy Hospital of Pittsburgh is participating in the Domestic Violence Medical Advocate Program. We are the urban center of the program, working in conjunction with the Women's Shelter of Pittsburgh, which is the local domestic violence shelter for the last 10 years.

There are two major thrusts to this program—education and program development. There has been a domestic violence medical advocate, a specific person who is charged with educating and raising the awareness about domestic violence in the hospital, beginning with the emergency department.

We have also set up a support and response system so that patients who are identified anywhere in the hospital and wish to be helped can be given any variety of options, including immediate safe shelter, follow-up contact and ongoing group support. The staff education and private assessment tools have dramatically raised the awareness and identification of victims of domestic violence.

We are beginning to understand and identify the victims of domestic violence. Women in abusive relationships need to understand the signs and to know that there are alternatives which are viable, safe, and available. Clearly, there needs to be a heightened awareness in our society of the characteristics of domestic violence.

On the practical side, I believe the greater identification will lead to greater utilization and the need for resources. If we are going to find more of them, we are going to need more resources. The Women's Shelter of Pittsburgh continually turns away patients on a regular basis because they are full.

Regardless of the current interventions, identification and early intervention with victims of domestic violence is an investment in our future by breaking the cycle, the generational cycle of violence. Any future health care planning should place a premium on values of human dignity for all.

[The prepared statement of Dr. MacLeod follows:]

Presentation to the Human Resources and Intergovernmental Relations Subcommittee

October 5, 1994

Bruce A. MacLeod, MD, F.A.C.E.P.
Chairman, Department of Emergency Medicine
The Mercy Hospital of Pittsburgh
Clinical Assistant Professor of Medicine
Division of Emergency Medicine
University of Pittsburgh

Domestic violence has been a part of our society for some time. It is only recently that we have begun to recognize its myriad of presentations, its consequences, and what might be some interventions. The syndrome of domestic violence carries societal stigma and complex social interactions. Victims of domestic violence that I have cared for in the emergency department are be afraid, ashamed, and confused all at the same time. There are complex societal expectations which might suggest that disputes between a man and a woman are "private matters" not to be discussed in public regardless of what transpires. This reminds me of when we began to look at child abuse and some parents felt that their interaction with their children was a "private matter".

Just as it is unacceptable to abuse a child, so too should we expect the interaction between a man and a woman to be compatible with the values of human dignity. In the emergency department I see the obvious effects of domestic violence: the bruises, broken bones, the physical trauma. I also see the indirect presentations of domestic violence. Women who present with somatic complaints which are coping mechanisms or manifestations of the persistent stress of their abusive environment. I also see the cycle of generational violence. The child learns domestic violence as a method to settle interpersonal disputes. This then becomes a learned behavior which shows up in the form of child abuse, spousal abuse, and other interpersonal violence. Just as child abuse is not a "private matter", just as motorcycle helmets are not a "private matter", domestic violence cannot be relegated to the sphere of a "private matter". I continue to see women in abusive relationships, with both psychological and physical abuse, who either don't recognize it or feel that this is their destiny, the hand that they were dealt which they are obligated to play out until the end. Our commitment to human rights should extend to these women.

Why has it taken us so long to recognize this epidemic of domestic violence. In the emergency departments, I believe that the delay is multifactorial with the two main reasons being: recognition and resources. Recognition of victims of domestic violence requires a high level of suspicion and a victim willing to ask for help. The victim of domestic violence can present to the health care practitioner with a wide variety of complaints beyond the obvious physical violence, such as: headaches, non-specific

abdominal pain, chest pain, and recurrent somatic symptoms. In our emergency department we have implemented a non-judgmental private assessment form which the patient completes in the privacy of the examination room. If she answers affirmatively the nurse or the physician can ask her if she would like help in a way which does not jeopardize her safety. The assessment form has been very important to the success of identifying domestic violence victims with non-specific complaints or with seemingly innocuous physical injuries.

I would like to take a moment to describe the Domestic Violence program at the Mercy Hospital of Pittsburgh. The Mercy Hospital of Pittsburgh is participating in the Domestic Violence Medical Advocate Program which is funded by Pennsylvania State legislation sponsored by State Senator Allyson Schwartz. This program is designed to assess the effectiveness of a Domestic Violence Medical Advocate in rural, suburban, and urban hospital settings. We are the urban center of the program working in conjunction with the Women's Shelter of Pittsburgh. There are two major thrusts of the program: education and program development. The domestic violence medical advocate is charged with educating and raising the awareness about domestic violence in the hospital beginning with the emergency department. She has also set up a support and response system so that patients who are identified, anywhere in the hospital, and wish to be helped can have any variety of options including immediate safe shelter, follow up contact, and ongoing group support. The staff education and the private assessment tool have dramatically raised the awareness and identification of victims of domestic violence.

We are only beginning to understand and identify victims of domestic violence. Society's view of domestic violence must continue to move from stigmatization of the victims and protection of the abuser. Women in abusive relationships need to understand the signs and to know that there are alternatives which are viable, safe and available. Clearly there needs to be a heightened awareness in our society of the characteristics of domestic violence. Since domestic violence crosses socioeconomic and racial lines, a mass media campaign would have to have a very broad dissemination. There could also be a campaign to raise the awareness of health care providers of the presentations of domestic violence in addition to developing suggestions for an effective, tested assessment tool.

Regardless of the current interventions, identification and early intervention with the victims of domestic violence is an investment in our future by breaking the generational cycle of violence. Any future health care planning should place a premium on values of human dignity for all.



Refer?

☐
Yes

☐
No

Referred to: _____

DOMESTIC SAFETY ASSESSMENT

Over the past several years, domestic violence has come to be recognized as an important, often overlooked, health issue in our society. The Mercy Hospital of Pittsburgh's mission is to care for our patients who are in need. We would like to help you identify whether you are a victim of abuse or neglect. To receive help is your decision - let us know if you have questions or would like to discuss your situation further. Following are some questions to help you and us evaluate if you are in an abusive situation. Please respond to them openly.

This information is part of your healthcare record. Your responses will not be released to anyone without your written consent, except as otherwise provided by law. If you do not feel comfortable talking today, you can call us at 232-8310.

1. Do you feel safe at home? ☐ Yes ☐ No
If no, why do you feel this way?

2. We all have disagreements - when you and your partner or a family member argue, have you ever been physically hurt or threatened? ☐ Yes ☐ No

3. Do you feel your partner or a family member controls (or tries to control) your behavior too much? ☐ Yes ☐ No

4. Does he / she threaten you? ☐ Yes ☐ No

5. Has your partner (or other family member) ever hit, pushed, shoved, punched or kicked you? ☐ Yes ☐ No

6. Have you ever felt forced to engage in unwanted sexual acts / contact with your partner or other family member? ☐ Yes ☐ No

If there are problems, we would like to help - please let us know.

1. Would you like to discuss your situation? ☐ Yes ☐ No

2. Would you like additional information on Domestic Violence? ☐ Yes ☐ No

3. Declined referral. ☐ Yes

MHC-78IH (7/93) [MDOMSAFE]
L-67000

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RN Signature _____

Date _____

Mr. TOWNS. Thank you very much, Dr. MacLeod.
Dr. Salber.

**STATEMENT OF PATRICIA R. SALBER, M.D., F.A.C.E.P., BOARD
OF DIRECTORS, AMERICAN COLLEGE OF EMERGENCY PHYSI-
CIANS**

Dr. SALBER. Good afternoon. I am Patricia R. Salber, M.D. FACEP. I am a board-certified emergency physician, assistant chief of the Emergency Department at Kaiser Permanente Hospital in south San Francisco, and a member of the board of directors of the American College of Emergency Physicians.

I am also the president and cofounder of Physicians for a Violence-free Society, a nonprofit organization dedicated to reducing violence in America. I am here today representing the more than 17,500 emergency physicians who are members of the American College of Emergency Physicians, which is also known as ACEP.

A battered woman's first opportunity to find support, assistance or protection may begin in her local emergency department or emergency medical services system. It has been estimated that somewhere between 15 to 20 percent of all women who present to emergency departments for any reason are there because of the health effects of domestic violence.

Emergency physicians working in collaboration with prehospital providers have a unique opportunity to identify victims of domestic violence and intervene to interrupt the cycle of violence, thereby preventing further abuse. ACEP believes that emergency physicians should provide compassionate, competent, and comprehensive care to victims of domestic violence, care that addresses not only the physical injuries, the medical complaints, and the psychological symptoms, but care which also addresses the source of those health issues, the domestic violence itself.

By recognizing the scope of the problem and undertaking measures for early intervention, emergency physicians have an opportunity to interrupt the pattern of domestic violence in their patient population and provide more effective treatment for these patients. ACEP is actively working to help our member physicians improve their response to domestic violence victims.

We know that to be maximally effective, emergency physicians must prepare their departments and hospitals ahead of time. We believe that every emergency department should have written policies and procedures to guide the management of victims of abuse. To assist in this effort, we have developed a resource document that identifies the key elements essential for effective domestic violence protocols.

This document is attached to the written testimony submitted for this hearing today. Further, ACEP believes that protocols must be combined with ongoing training programs. These protocols and training programs should include information about the definition and dynamics of domestic violence, specific guidance on how to make the diagnosis and how to assess the victims' safety as well as suggested interventions and referrals.

All emergency departments should have up-to-date written materials with names and telephone numbers of local shelters, advocacy groups, and legal assistance organizations which can be made

available to domestic violence victims. But emergency physicians must go beyond telephone numbers and addresses. They must establish collaborative relationships with both hospital and community-based resources who provide essential services to victims of domestic violence.

We understand that the most effective programs for those victims are those that utilize all available services and resources in a community, both within and outside of the hospital environment. ACEP believes that educational programs in domestic violence are essential for practicing emergency physicians as well as residents, medical students, and prehospital providers.

The college has worked with other organizations to add domestic violence to the core content of emergency medicine for residency programs. They have included continuing medical education courses on domestic violence at their annual scientific assembly and other educational meetings, and they have published materials on domestic violence, adult sexual abuse and rape in their award winning home study program.

In 1992 the college established a domestic violence task force and has recently approved a policy entitled, "Emergency Medicine and Domestic Violence," that emphasizes the importance of the emergency department evaluation of patients for domestic violence.

ACEP lobbied for the passage of the recently enacted Violence Against Women Act and worked with more than 140 organizations to provide funding to existing programs in domestic violence. We have also strongly supported the Centers for Disease Control activities including actively lobbying to increase funding for the National Center for Injury Prevention and Control, and I have included in the written testimony some specific recommendations about programs and research that the CDC should consider in order to decrease the incidence of domestic violence, and I think, Mr. Chairman, you may be interested to know that we did have recommendations that the CDC take a look at interventions for batterers and studied successful batterer intervention programs.

In closing, I wish to reiterate that ACEP believes that physicians and particularly emergency physicians can play an important role in domestic violence intervention and prevention. We are committed to educating emergency physicians about the nature and impact of violence in our society, and we are taking substantive steps toward reducing the epidemic of domestic violence which is gripping our Nation today. Thank you.

[The prepared statement of Dr. Salber follows:]

TESTIMONY OF
THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

BEFORE THE

HOUSE GOVERNMENT OPERATIONS COMMITTEE
SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

WEDNESDAY, OCTOBER 5, 1994

Good morning, I am Patricia R. Salber, MD, FACEP. I am a board certified emergency physician, assistant chief of the emergency department at Kaiser Permanente Hospital in South San Francisco, California, and a member of the American College of Emergency Physician's (ACEP) Board of Directors. I am also the President and co-founder of Physicians for a Violence-Free Society. I am here today representing the more than 17,500 emergency physicians who are members of ACEP.

In my discussion today, I will make several major points. First, domestic violence, is a widespread public health problem that occurs among all age, race, and socioeconomic groups. Second, emergency physicians, in a coordinated effort with other health and social service providers, can play an important role in breaking the cycle of domestic violence. Third, education and training in the identification, assessment, and intervention in domestic violence should be included in the training programs for medical professionals, including emergency physicians. Fourth, additional data collection and research is needed to better understand and help prevent domestic violence and to assess existing treatments for its victims and perpetrators. Finally, I will describe the activities of the American College of Emergency Physicians in addressing the epidemic of domestic violence.

DEFINITION AND FACTS ABOUT DOMESTIC VIOLENCE

ACEP defines domestic violence as a part of a pattern of coercive behaviors which an individual uses to establish and maintain power and control over another with whom he/she has or has had an intimate, romantic, or spousal relationship. These behaviors include: actual or threatened physical or sexual abuse, psychological abuse, social isolation, deprivation, and intimidation. Domestic violence is part of a broader spectrum of family violence that includes sexual assault, child, and elder abuse and neglect.

The past twenty years have seen the birth of a new national awareness of the impact of family violence upon our national health care resources. Domestic violence has been recognized by the Surgeon General as a major public health problem that has reached epidemic proportions in the United States. It accounts for more injuries and deaths to women than rape, mugging, and auto accidents combined.

There are no typical victims of domestic violence. It occurs among all races and socioeconomic classes, and in families of all educational backgrounds. The individuals involved may be living together or separated, divorced, or even prohibited from contact by temporary or permanent restraining orders.

The FBI estimates that a woman is battered every 5 to 15 seconds, and 30 percent of women who were murdered in 1990 were killed by husbands or boyfriends. Violence occurs in at least half of all US marriages; and for 25 percent of these couples, violence is a common occurrence. Estimates show that 1 of 6 women in the United States are, or have been, victims of domestic violence. An estimated 8-12 million women in the United States are at risk of being abused by their current or former intimate partners.

The financial impact of domestic violence on the health care delivery system is enormous. A recent study estimates the cost for caring for victims of domestic violence, including prehospital services, medical and mental health care treatment, insurance administrative costs, and rehabilitation services to be \$1.25 billion in 1993.¹ When one considers in addition the tremendous emotional costs to the victim, their family and friends, and the effects of domestic violence on the workplace, school, and the community in general, it is clear that this is one of the most serious public health problems facing our nation today.

ROLE OF EMERGENCY MEDICINE IN ADDRESSING DOMESTIC VIOLENCE

Many victims of violence enter the health care system through the emergency medical services system and hospital emergency departments. Current estimates are that approximately 15 percent of women seeking care in an emergency department for any reason are victims of domestic violence. About 75 percent of battered women first identified in a medical setting will go on to suffer repeated abuse. Consequently, prehospital and emergency department health professionals are frequently called upon to care for victims of domestic violence.

A battered individual's first opportunity to find support, assistance, or protection may begin with the emergency medical services system and their local emergency department. Emergency physicians, working in collaboration with prehospital providers, are uniquely positioned to identify domestic violence, interrupt the cycle of violence, and prevent

¹Miller T. R., Cohen M. A., Wiersema B., *Crime in the U.S. Victim's Costs and Consequences* discussion draft. National Public Service Research Institutes. August 1994.

further abuse.

Pre-hospital care and domestic violence

Pre-hospital providers of health care, including emergency medical technicians and paramedics, are often the first point of contact between the victims of domestic violence and the emergency medical services (EMS) system. For domestic violence cases, specialized training is needed for EMS professionals to address scene dynamics, the potential for harm to the health care provider, and the need for special documentation and communications.

ACEP recommends the revision of the initial educational curricula of prehospital providers to encourage training in the treatment of victims of domestic violence. This would include the recognition of victims and injury patterns, an understanding of the cycle of abuse and how this affects care, scene safety, preservation of evidence and documentation requirements. ACEP would also recommend that continuing education programs be implemented to reach those personnel who have already received initial training.

Detection of domestic violence and the barriers to physician intervention

Emergency physicians should provide compassionate, competent and comprehensive care that addresses not only physical injuries, or medical or psychological symptoms, but the source of those injuries as well. Battered individuals present to emergency departments with a myriad of complaints, some of which are physical injuries. But victims may also seek care in the emergency department with a variety of medical presentations such as anxiety, depression, chronic pain syndrome (such as headache, pelvic pain, and chest pain syndromes). By recognizing the scope of the problem and undertaking measures for early intervention, emergency physicians may be able to interrupt the pattern of domestic violence in their patient population, therefore providing a more effective treatment for these patients.

Detection of domestic violence is a real challenge for emergency physicians. Studies indicate that the detection, documentation, and treatment of domestic violence victims in the emergency department needs to be improved.² ACEP believes that emergency physicians and other hospital emergency department staff must first recognize and address the barriers that can prevent detection.

Some of these barriers are described below:

²Centers for Disease Control and Prevention, Emergency Department Response to Domestic Violence - California, 1992. *Journal of the American Medical Association* 1993;270:10:1174-1176.

- * Lack of familiarity with the emotional, psychological, and social issues which can predispose a victim to continue to return to abusive environments.
- * Lack of familiarity with the clinical presentations of domestic violence.
- * Misconceptions about abuse which prevents medical professionals from considering this possibility with their patients. For example, they may be concerned that they should not intrude into the family unit, or feel that if victims wanted to, they could leave the abusive situation.
- * Emergency physicians are trained in the rapid recognition and stabilization of acute medical emergencies, and may place less emphasis on psychosocial factors of their patients' illness and injury. And the acute, episodic nature of the care they provide places them at a disadvantage for recognizing the progressive signs and symptoms of domestic violence in their patients.
- * Medical personnel may miss the diagnosis of domestic violence because the signs of violence can vary depending upon the type of abuse and the victim's position in the family. Abused children may be passive or withdrawn; adults may be reluctant to speak of the problem or not volunteer the information; or the physician may fail to ask directly about the possibility of abuse.

However, since emergency physicians are among the first non-family members to whom the victim turns for help, they have a special opportunity and responsibility to intervene when possible. ACEP is working to better educate all emergency physicians about the signs of abuse and ways that physicians can appropriately intervene.

IMPROVING THE EMERGENCY DEPARTMENT RESPONSE TO DOMESTIC VIOLENCE

ACEP is taking several important steps in order to improve the emergency department response to domestic violence victims and assist emergency physicians in dealing more effectively with this issue. Because there is such a variety of manifestations of domestic violence, ACEP believes that emergency physicians should consider domestic violence in evaluating patients presenting to the emergency department. It is the policy of ACEP that:

- * the identification and assessment for domestic violence is an important, specialized part of the evaluation of the emergency patient;
- * emergency medical services (EMS), medical school, and emergency medicine residency training programs should incorporate training for identification, assessment, and intervention in domestic violence in their curricula;

- * a collaborative interdisciplinary approach with emergency physician leadership should be used to: collect data on the incidence and extent of domestic violence, develop clinical and academic research on domestic violence, and use this information to detect, diagnose, and intervene with these patients;
- * hospitals should develop multi-disciplinary approaches including policies and protocols for emergency department identification, treatment, and referral of domestic violence patients;
- * the special nature of and the necessary resources for the domestic violence screening evaluation and examination should be recognized.

Domestic violence identification, assessment, and intervention in the ED

As there is no unique presentation for victims of domestic violence, ACEP recommends that emergency physicians routinely question patients about domestic violence. A simple questionnaire may be helpful in detecting victims of domestic violence. Screening should start with the triage nurse and continue throughout the emergency department evaluation process. All patients should be screened privately. Patients should be reassessed by the physician, just as for any medical illnesses. Emergency physicians should become familiar with techniques to separate partners or caretakers who refuse to leave during the patient's evaluation.

Just as are assessments for smoking, drinking, drugs, and sexual history, domestic violence assessment should be considered as a routine part of every history. Domestic violence victims often present to the emergency department with complaints that, on the surface, may have no apparent relation to violence. Without a careful and directed history to address the issue of domestic violence, information will be lost. Most victims will be relieved, rather than offended, by direct, non-judgmental questions.

Physicians can gain clues from observing the patient and his or her partner. The patient may seem evasive, embarrassed or inappropriately unconcerned with his or her injuries while the partner may be overly solicitous and answer questions for the patient. Or, the partner may be openly hostile, defensive or aggressive, setting up communication barriers between emergency personnel and the patient.

Increased attention to detail is critical in detecting signs of domestic violence in the physical examination. Patients should be thoroughly examined for concealed bruising and other injuries. Maintaining comprehensive and exact documentation is of great importance for domestic violence victims. If injuries are inconsistent with the history, this should be addressed with the patient in a non-confrontational manner. The patient should be reminded that violence can escalate over time. Even if the patient still denies violence, the message of concern has been delivered and the patient is aware of a potential resource.

Since the patient's safety is a high priority, physicians or other emergency department staff should try to determine, along with the patient, if it is safe for the patient to return home. The patient should be given some simple but powerful messages: (1) She is not alone; there is help available; (2) The emergency physician and the emergency department staff care; and, (3) She does not deserve to be beaten. The patient should be advised of all options, including legal and community service alternatives, and should be empowered to make the best decision for herself.

Incorporating domestic violence topics in the education of emergency providers

ACEP believes that curricula and continuing medical education programs should be established for practicing emergency physicians, residents, medical students and EMS providers about the prevalence and significant medical, financial and psychosocial consequences of domestic violence. In fact, residency training programs in emergency medicine are already required to educate residents in domestic violence, and, additionally, the specialty of emergency medicine is in the process of improving and focusing these requirements.

ACEP, in cooperation with the American Board of Emergency Medicine, and the Society for Academic Emergency Medicine, is revising and updating the *Core Content for Emergency Medicine*. ACEP has recommended that the new version include a more focused emphasis on domestic violence detection and treatment. The *Core Content* is a document used to guide the education and training of emergency medicine residents in both clinical and didactic elements of emergency medicine. The Emergency Medicine Residency Review Committee, a body of the Accreditation Council on Graduate Medical Education, uses the *Core Content* list to evaluate the resulting curricula developed by residency programs in emergency medicine. The *Core Content* is also used by ACEP in developing its continuing medical education programs for emergency physicians.

The current version of the *Core Content* already cites family violence as a topic to be covered in numerous clinical and management categories. Curricula covering pediatric disorders, for example, should address abuse including subtopics of neglect, physical abuse, and sexual abuse. The urogenital/gynecological category directs that sexual assault be covered.

Legislation that would require all health profession schools to incorporate a HHS-approved curriculum on domestic violence or face a loss of federal grant funding has been introduced by Congressman Ron Wyden and Senator Barbara Boxer in HR 3207. Rather than promoting education in domestic violence through penalties, ACEP would prefer an approach that addresses the issue in a manner that would allow each health professions institution to develop its own curriculum in the area, within the framework of accreditation guidelines. ACEP has learned that such an approach was developed jointly by Congressman Wyden and the Association of American Medical Colleges earlier this year, and was intended to be included as an amendment to the Health Security Act.

Although the demise of comprehensive health care reform effectively eliminated this option this year, ACEP would support such legislation in the next Congress.

Collaborative approaches on data collection and research in domestic violence

ACEP strongly supports the Centers for Disease Control and Prevention (CDC) activities related to preventing injuries and deaths caused by violence against women. The College has actively lobbied to increase funding to the CDC's National Center for Injury Prevention and Control. Through working collaboratively with public and private organizations in the prevention of violence against women, CDC has been successful in helping to make domestic violence a priority in the United States.

Additional data collection and research is needed in order to better describe and track domestic violence, to determine the effectiveness of specific interventions in preventing family and intimate violence, and to identify factors associated with domestic violence that are able to be modified.

Some of the areas in which research should be expanded are outlined below:

- * Current domestic violence models focus more heavily on treatment than on prevention of the problem. Therefore, research on the causes and prevalence of domestic violence is vital. In addition, research to substantiate the effectiveness of prevention programs is not available, but should be supported. ACEP believes that each state should work cooperatively toward uniformity in data collection procedures, and that funds should be available to support this effort.
- * Studies to determine the effectiveness of current laws, investigative procedures, and intervention or treatment programs are needed. For instance, although most states have laws which require that criminal assault be reported, a few states, such as California and Arizona, specifically require that domestic violence be reported. However, there is currently not enough data available to indicate whether mandatory reporting ensures or diminishes the safety of adult victims of domestic violence. The experience in California, where a mandatory reporting law went into effect in January, 1994, is that some women may choose not to access emergency departments or other health care providers because they do not want the incident reported to police.
- * Research is needed to determine the factors that predispose individuals to become perpetrators of family and other forms of violence. Once these factors are identified and confirmed, early intervention programs should be designed for individuals likely to become perpetrators.
- * The rate of recidivism in battery treatment programs for perpetrators is high. However, because some individuals are successful in changing their abusive

behavior, research should be conducted into determining which factors are important in changing this behavior.

- * Support is needed for the development of community-wide programs that go beyond improving the response for victims of domestic violence, and attempt to change community attitudes in order to make domestic violence unacceptable. For example, the Family Violence Prevention Fund has published an educational campaign called, "There Is No Excuse For Domestic Violence" aimed not just at victims and perpetrators, but at community attitudes.
- * Support for the increased use of E codes is important. ACEP has long promoted the use of E codes by emergency physicians. E codes, or external cause of injury codes, are a supplement to the International Classification of Diseases codes, which provide a systematic way to classify cause of injury information that doctors, nurses, paramedics, and social workers may put in the patient's medical record. They may be grouped into large categories to classify falls, firearm injuries, assaults, etc., they may be precise, such as E967 - Child Battering and Other Maltreatment. Although there are none that specifically address adult domestic violence, E codes are helpful in that they recreate a picture of the specific circumstances of an injury, and in conjunction with other data, E codes become the foundation for many injury prevention activities to make communities safer.

Development of multi-disciplinary policies and protocols for the emergency department

The Public Health Service's national health objective for the year 2000 calls for at least 90 percent of hospital emergency departments to have protocols for routinely identifying, treating, and referring victims of sexual assault and spouse abuse. To contribute to meeting this goal, in 1992, the Joint Commission on the Accreditation of Health Care Organizations instituted a requirement that all emergency departments and ambulatory care facilities have written policies and procedures to guide the identification and care of victims of domestic violence, including elder abuse, child abuse, and sexual assault. For all of these conditions, the Joint Commission now requires that hospital procedures address patient consent; examination and treatment; the hospital's responsibility for the collection, retention, and safeguarding of specimens, photographs, and other evidentiary material; and, as legally required, notification and release of information to the proper authorities. The Joint Commission also requires that a list of referral agencies be kept; that the medical record adequately document examination, treatment, and referral; and that staff be educated about identifying and treating abused patients.

As a resource for this effort, ACEP has developed a document that identifies the key elements for domestic violence protocols (attached). Further, ACEP believes that on-going protocols and training programs for emergency department personnel should include information about the definition and psychodynamics of domestic violence, specific information on making the diagnosis, and suggested interventions. To avoid confusion

and standardize responses, the roles of all health care professionals, including nurses, physicians, social service providers and others, should be clearly defined in these protocols.

Every emergency department should have written material with the name and telephone numbers of local shelters, advocacy groups and legal assistance that can be provided if the patient feels it is safe to do so. Emergency physicians should be encouraged to establish relationships with these community resources, including developing an understanding of their capacity and philosophy. They need to know how law enforcement and prosecutors respond to cases of domestic violence, and the reporting requirements in their states.

The most effective programs for managing the victims of domestic violence will be those that utilize all available services and resources, both within and outside of the hospital environment. Therefore, ACEP strongly believes that an effective approach to dealing with domestic violence requires a well-planned, collaborative effort. In addition to physicians, these efforts must involve the security services and other ancillary staff in these plans in order to provide the comfort and security essential for effective intervention. In addition, comprehensive intervention with victims of domestic violence will require the involvement of services external to the hospital. ACEP encourages emergency departments to become full and active participants in a coordinated community response, including resources such as law enforcement, legal advocacy, women's and homeless shelters, counseling services, support groups, child care services, and other social service organizations.

OTHER ACEP INITIATIVES

ACEP and its members are actively involved in efforts to break the cycle of domestic violence.

- * ACEP lobbied for passage of the recently enacted Violence Against Women Act and worked with more than 140 organizations to provide funding to existing programs for domestic violence victims.
- * An ACEP Domestic Violence Task Force was established in 1992 and this year, the issue is being addressed by our Trauma Care, Violence and Injury Control Committee.
- * In 1992, ACEP's Board of Directors approved a policy on elder abuse and neglect that emphasizes the responsibility of emergency physicians to recognize, manage, and when appropriate, report suspected cases of elder abuse.

- * In September of 1994, ACEP's Board of Directors approved the policy, "Emergency Medicine and Domestic Violence" that emphasizes emergency physicians should consider domestic violence in evaluating patients presenting to the emergency department.
- * ACEP has prepared materials on child physical abuse, sexual abuse and neglect for the Advanced Pediatric Life Support (APLS) course instruction manuals. The College has also published home study program materials on rape, adult sexual abuse, suspected child abuse, geriatric abuse, and domestic violence. Since 1991, ACEP's annual scientific meeting has included continuing medical education courses on domestic violence.
- * In March of 1994, ACEP was a co-sponsor of the AMA's National Conference on Family Violence, Health and Justice. This invitational conference was intended to improve the response of the health and justice systems to family violence and foster collaboration among the various organizations present. Two emergency physician members of ACEP, including myself, participated on a medical panel that examined the difficulties a victim of domestic violence may encounter in accessing both the medical system and the justice system.
- * ACEP hosted the AMA's National Advisory Council on Family Violence meeting in Dallas Texas in April, 1994. ACEP's Vice President, Dr. Larry Bedard, FACEP is the Chairman of this Advisory Council's Steering Committee. There are also several other emergency physicians on this council.

Several of ACEP's state chapters have made strong in-roads on the issue of domestic violence with the media and the public.

- * The New York ACEP chapter held a conference on domestic violence and abuse that garnered attention and spurred emergency physicians in other states to focus on the issue.
- * ACEP's California emergency physicians held a seminar on violence in 1993 which attracted national media attention. California ACEP also worked with state legislators to formulate legislation to improve the response to domestic violence.
- * The Ohio and Maine chapters of ACEP have developed protocols and collected a great deal of information about recognizing and treating victims of violence in the emergency department. Other state chapters, such as Pennsylvania and New Jersey, have been active in this area by providing information to members in monographs, newsletters, and other materials.

- * Emergency physicians in Hawaii received an ACEP chapter grant for FY 1992-1993 to develop an educational tool for physicians on domestic violence prevention. It also initiated a campaign called "Blow the Whistle on Violence", with support from ACEP, as well as broad community and corporate support.

CONCLUSION

ACEP believes that physicians, and particularly emergency physicians, have a powerful voice in the campaign against domestic violence. Emergency physicians have credibility in the communities in which they provide care for people. ACEP's activities are intended to educate physicians about the nature and impact of violence on society and take steps toward breaking the cycle of domestic violence across this nation. In order to accomplish this, the College must ensure that physicians have the necessary information and support to incorporate violence prevention into their practices.

ACEP appreciates the opportunity to present our views in this very important hearing. We would be pleased to continue to assist the Committee in the future. I would be happy to address your questions on this topic.

LIST OF KEY ELEMENTS OF FAMILY VIOLENCE PROTOCOLS

1. Criteria for **Identification** must address:

physical assault

sexual assault

abuse or neglect of:

elders

spouses

partners

children

persons with disabilities

2. Procedures for **Evaluation** must address:

patient consent for:

medical examination

collection of evidence

release of information

photographs

roles and responsibilities of members of ED staff:

EMS

security staff

intake staff

triage staff

social services

provider staff:

interview

examination

collection of physical evidence

photographing injuries

reporting the incident

patient confidentiality

treatment plan

hospital's responsibility for chain of evidence

notification of and release of information to proper authorities as required
in each state

3. Consideration of **Safety** of patient and provider staff
4. **Referral** to another location or organization for evaluation and treatment when appropriate
5. **Aftercare** and referral to community agencies
6. Medical record **Documentation** must include:
 - examinations
 - treatment
 - referrals
 - reporting as required by state law
7. **Education** plan for staff, must include providing emotional support for staff
8. **Prevention**, which should include:
 - risk assessment
 - interaction with batterer
 - patient education
 - community issues
9. **Quality Assessment and Management** program
10. Appendices

Mr. TOWNS. Thank you very much, Dr. Salber.
Dr. Goodman.

**STATEMENT OF LISA GOODMAN, Ph.D., AMERICAN
PSYCHOLOGICAL ASSOCIATION**

Dr. GOODMAN. Thank you, Mr. Chairman. My name is Lisa Goodman, and I am pleased to be here today on behalf of the American Psychological Association to discuss the mental health effects of domestic violence. I am an assistant professor of psychology at the University of Maryland at College Park. I am also cochair of the American Psychological Association's task force on male violence against women and coauthor of the book that summarizes the work of that task force. The book is titled, "No Safe Haven: Male Violence Against Women At Home, At Work, And In The Community."

The task force on male violence against women was established by the American Psychological Association in the fall of 1991. Its mandate was to review psychological research on violence against women, to describe existing interventions and to recommend education, research, training, and policy initiatives to address the problem.

My testimony today will focus first on domestic violence as a public health issue. I will then review what is known about the psychological effects of domestic violence and briefly outline recommendations in the areas of treatment and research. Since my time is limited, I request that my written statement be submitted for the record.

Mr. TOWNS. Without objection.

Dr. GOODMAN. Glad to hear it. Domestic violence is a serious and widespread problem that affects women of all racial, ethnic, and socioeconomic groups. As you have heard today, experts estimate that nationally as many as 4 million women are severely assaulted by their male partners in an average 12-month period, and that a minimum of 21 percent of all women will be physically assaulted by an intimate male at least once during adulthood.

For the women affected, this violence takes a tremendous physical and psychological toll. While some may view domestic violence as a private matter, the fact that battering is the single most common cause of injury to women between the ages of 15 and 44 clearly indicates that domestic violence is a public health problem of major proportions.

Women who are abused by their male partners suffer a wide range of physical injuries, including bruises, cuts, torn ligaments, and bone fractures. They also frequently suffer psychological injuries, such as severe depression, acute anxiety and chronic insomnia. These psychological injuries can be just as traumatic and damaging as physical effects, but may take longer to heal and in many cases may never heal if the woman is unable to obtain appropriate treatment.

Women's emotional reactions to domestic violence follow a typical pattern. During the actual assault, the woman's primary focus is on self-protection and survival. In the aftermath of the assault, the woman may experience severe levels of depression, thoughts of suicide, and actual suicide attempts. In addition, she may use drugs

or alcohol in an effort to find some temporary psychological escape from the abuse.

Over the past few years, studies have shown that many of the symptoms women develop when they are abused taken together are indications of post traumatic stress disorder. This psychological disorder is seen often in soldiers who have fought in military combat, prisoners of war, victims of torture, and people who have survived natural disasters such as earthquakes and floods.

Symptoms of PTSD include long-term fear or terror, frequent nightmares and flashbacks to the traumatic incident, chronic anxiety and hypervigilance, denial, avoidance, loss of memory for parts of the traumatic episodes, and psychic numbing.

Although the task force developed a broad range of recommendations, I would like to focus here on those involving mental health treatment and research.

While it is important to increase the general public's awareness of the psychological toll of domestic violence, as you have heard here today it is essential that efforts also be made to educate health and mental health providers. If mental health service providers who treat women are unaware that domestic violence may be a cause of women's psychological difficulties, they will be unlikely even to ask female clients whether they have been victims of domestic violence, let alone to design appropriate interventions.

Mental health interventions for female victims of violence should therefore include the following: Routine screening for histories of victimization; safety planning; coordination with grassroots services, such as safe houses, crisis lines, support groups, and legal services; expanded intervention for men who physically or sexually assault their female partners; and expanded interventions for children and adolescents who have witnessed violence between adult caretakers.

Along with treatment needs it is equally important to continue research on the many aspects of domestic violence to ensure that the most effective interventions are developed, and as my time is up, I will just let you know that a list of critical areas in need of further empirical assessment are set forth in my written testimony. Thank you for the opportunity to speak here today.

[The prepared statement of Dr. Goodman follows:]



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

TESTIMONY OF

Lisa Goodman, Ph.D.

University of Maryland, College Park

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

before the

**HOUSE OF REPRESENTATIVES
HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS
SUBCOMMITTEE
OF THE
COMMITTEE ON GOVERNMENTAL AFFAIRS**

on the subject of

MENTAL HEALTH ASPECTS OF DOMESTIC VIOLENCE

October 5, 1994

The Honorable Edolphus Towns, Chair

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Mr. Chairman and members of the Subcommittee, my name is Lisa Goodman and I am pleased to be here on behalf of the American Psychological Association (APA) to discuss the issue of mental health aspects of domestic violence. The American Psychological Association is the largest organization representing psychology and has over 124,000 members and affiliates. I am an assistant professor of Psychology at the University of Maryland at College Park. I am also a co-chair of APA's Task Force on Male Violence Against Women and co-author of the book that summarizes the work of the Task Force: No Safe Haven: Male Violence Against Women at Home, at Work, and in the Community.

The Task Force was established in the fall of 1991 by the APA's Committee on Women in Psychology. Its mandate was to review current research on the prevalence, causes, and impact of several different forms of violence against women; to describe community-based and clinical interventions designed to provide housing, medical, psychological, and legal assistance; and to recommend research, education and training, and policy initiatives to address the problem. My testimony today will summarize the findings of the Task Force as they relate to domestic violence, which the Task Force defines broadly as violence within intimate relationships.

I will focus my discussion on the psychological effects of both sexual and nonsexual domestic violence. I will also address the prevalence of partner abuse and what is known about intervention and treatment for domestic violence. Finally, I will discuss those steps which the psychological community believes are needed to combat domestic violence.

Definitions of Domestic Violence

One of the major issues confronting the Task Force was how to define abuse - that is, what behaviors and actions to include in the definition. On the one hand, we did not want to veer from, or dilute the power of, the traditional and popular understanding of domestic violence as the use of physical force in intimate relationships. On the other hand, we recognized that men's actual use of physical force against women lies on one end of a continuum of behaviors, all of which involve men's abuse of power over women, either through physical strength or control of economic resources.

Abuse in couple relationships takes many forms: intense criticisms and put-downs, verbal harassment, restraint of normal activities and freedoms, denial of access to economic and other resources, sexual coercion and assault, and physical intimidation and attacks. Although all of these types of abuse have significant impacts on women, my testimony today will focus primarily on acts of physical aggression, defining the term *violence* more narrowly to connote *forcible restraint, sexual aggression, or physical assault with the potential to cause physical harm, and threats to harm or kill*. These types of abuse are found in all types of intimate partner relationships: between partners who are dating, cohabiting, or formerly married (either separated or divorced), as well as between married partners.

Domestic Violence as a Public Health Issue

Domestic violence is a serious and widespread problem that affects women of all

racial, ethnic, and socioeconomic groups. In 1985, at the Surgeon General's Workshop on Violence and the Public Health, former Surgeon General Koop stated that domestic violence is one of the major public health problems in America today, as much a public health issue as communicable disease control was during the last two centuries.

The extent of domestic violence is difficult to detect. National estimates are derived from self-reports obtained through telephone or in-person interviews. Such surveys typically do not include the very poor; those who do not speak English fluently; those whose lives are especially chaotic and who are therefore difficult to reach; military families living on base; and individuals who are hospitalized, institutionalized, incarcerated, or homeless at the time the survey is conducted. Furthermore, estimates are based on those respondents who are home when the interviewers knock or call, who are willing to talk with interviewers, and who are willing to report, even anonymously, acts of violence they have experienced or perpetrated in their relationship. As a result, most national prevalence estimates represent conservative estimates, if not marked underestimates, of the problem.

Keeping this in mind, on the basis of the last 17 years' empirical findings, experts estimate that the national prevalence of physical abuse may be as high as 4 million women severely assaulted by their male partners in an average 12-month period and that a minimum of 21 percent of all women will be physically assaulted by an intimate male at least once during adulthood. More than half of all women murdered in the United States in the first half of the 1980s (52%) were killed by their intimate partners. And, using a conservative definition of rape, a study of 930 women found that 14 percent of ever-married women reported being raped by a husband or ex-husband. In several empirical studies using detailed questions and face-to-face interviews by female interviewers, between 34 percent and 59 percent of women who reported non-sexual assault by male partners also reported sexual assault.

For the women affected, this violence takes a tremendous physical and psychological toll. The former Surgeon General Antonio Novella announced in 1992 that domestic violence is the leading cause of injuries to women age 15-44. Furthermore, although the intergenerational transmission of violent intrafamilial relationships is not inevitable, studies show that children reared in violent homes are at an elevated risk of becoming abusers themselves, in adulthood, thus perpetuating a cycle of violence. Clearly, domestic violence is not simply a "private" matter: it is a major public health problem that cannot be ignored.

Who are the Perpetrators?

Contrary to traditional assumptions that violent victimization occurs primarily between strangers or acquaintances, women's greatest risk of physical assault is from their intimate partners. Women are more likely to be repeatedly attacked, raped,

injured, or killed by their partners than by other types of assailants. This repetition and severity of aggression is facilitated by the fact that since intimate partners have frequent contact, the amount of time at risk is high. Additionally, assaults can be carried out in private when the target is off-guard and where there are no witnesses that might inhibit the aggressor.

Women are also at greater risk of sexual assault by male intimates than by strangers. Rape by male partners seems to occur most frequently in relationships in which other forms of physical aggression are ongoing. Violent episodes often include sexual as well as physical attack; and, men who are both physically and sexually aggressive perpetrate more severe levels of non-sexual aggression than do other abusers.

Who Are the Victims?

While domestic violence occurs in all racial, ethnic and socioeconomic groups, it is possible that certain factors, such as age, income, or race or ethnicity, may put women at greater risk for becoming victims of partner abuse. However, the research to date in this area is inconclusive because there is little research available on domestic violence broken down by these factors. The little research that exists suggests that race and ethnicity alone do not distinguish violent and nonviolent couples. Additional research is needed to identify the range of factors that put women at higher risk for domestic abuse so that preventive interventions can be targeted more effectively.

Traditionally, researchers have sought to understand the dynamics of abusive relationships by focusing on the characteristics of the women in those relationships – how they cope with the abuse and what factors put them at risk. In comparison, very little attention has been given to the abusers, though one study found that the characteristics of the man with whom the woman is involved are better predictors of a woman's risk of becoming a victim than are characteristics of the woman herself. It is essential that more research be focused on explaining why abusive men are violent, what factors put them at greater risk for abusing their intimate partners, and what interventions are effective in stopping their violent behavior.

Psychological Effects of Partner Violence

Women who are abused by their male partners suffer a wide range of physical injuries. But they are also at great risk for psychological injury. It is easy to measure the physical damage caused by an abusive partner: you can see the bruises, cuts, and bone fractures. It is more difficult to measure the psychological distress and negative effects on mental health, such as severe depression, acute anxiety, and chronic insomnia due to fear of being assaulted while sleeping. However, the psychological effects of domestic violence can be as traumatic and damaging as the physical effects; they may take longer to heal, and in many cases may never heal if the woman is unable to obtain appropriate treatment.

Although generalizations cannot be made to the entire population of women who experience domestic violence, research indicates that domestic violence is clearly a major cause of psychological distress, though women experience negative psychological effects in varying degrees. The number and severity of these effects will vary according to numerous contextual variables, including a woman's intrapsychic and interpersonal resources, and the amount, severity, and duration of violence she has experienced.

Women's reactions to violence by male partners closely parallels the reactions of people who have experienced other traumatic events. During the assault, battered women's primary focus is on self-protection and survival. Reactions of shock, denial, withdrawal, confusion, psychological numbing, and fear are common. During and after an assault, a victim may offer little or no resistance in an attempt to minimize the threat of injury or renewed aggression.

Following physical assaults by male partners, women frequently report severe levels of depression, thoughts of suicide, and suicide attempts. Longstanding abuse or a particularly severe assault may cause some women to use drugs or alcohol in an effort to self-medicate, i.e. to find some temporary psychological escape from the abuse. Over the past few years, studies have shown that the symptoms women develop when they are abused, taken together, are indications of Post-Traumatic Stress Disorder (PTSD). PTSD is defined as a constellation of symptoms that occur following exposure to a traumatic event that involves a threat of death or serious injury to oneself or a family member. The likelihood of developing this disorder may increase with increased physical proximity to the stressor, and may be especially severe or long lasting when the stressor is interpersonal and intentional, as compared to the traumatic experience of a severe accident or natural disaster. This psychological disorder is seen often in soldiers who have fought in military combat, prisoners of war, victims of torture, people who have been physically or sexually assaulted, and people who have survived natural disasters, such as earthquakes or floods. The symptoms of PTSD include long-term fear or terror, frequent nightmares and flashbacks to the traumatic incident(s), chronic anxiety and hypervigilance, denial, avoidance, memory loss of part of the traumatic episode, constricted affect, and psychological numbing.

Noting the similarities between battered women and prisoners of war, one study compared the patterns of abuse and response of male prisoners of war in Korea with women in abusive adult relationships. Three dimensions of abuse were identified as common to both types of experiences:

- a) psychological abuse that occurs within a context of threatened physical violence and leads to dread and debilitation in victims;
- b) isolation of victims from past support systems (e.g., friends and family) and from outside activities that results in dependency on the abusers and validation of the abusers' actions and points of view; and,

- c) intermittent positive reinforcement in the face of fear and personal loss that strengthens the emotional victims' dependency on their abusers.

Although even one assault can have permanent negative effects, long-standing violence in particular has a major impact on the incidence and severity of psychological reactions. In a nationally representative sample of 336 women, researchers found that the more violence a woman experienced, the more she suffered from various forms of psychological distress and negative mental health effects. Exposed to repeated attack and threat, abused women often live with increasing levels of isolation and anticipatory terror. Research has shown that, although shock is the predominant emotional response initially, other emotional reactions intensify over time. In one study, clinically significant levels of fear, anxiety, and depression were reported at higher levels after the third battering incident, whereas shock at being victimized decreased.

Responding to the Violence: Why do Women Stay?

In one study, less than one quarter of the women left the relationship even temporarily after the first major assault; even after the third attack, only 31 percent sought outside help and only 15 percent took offensive action against their mates. A question that is frequently asked is, "why do women stay in an abusive relationship?" First, many abused women are economically dependent on their violent partners, and may not have family and friends who will support them, even temporarily, particularly if they have children. For this reason, they may feel unable to leave an abusive relationship.

Second, like other victims of interpersonal violence, women assaulted by male intimates learn to judge all their options against their perceptions of the assailant's ability to control or to harm. Behaviors that outside observers may interpret as helplessness – such as staying with the abuser or refraining from initiating legal actions against him – may be based on accurate evaluations of the assailant's potential for violent responses if they should leave or have the abuser arrested, and others' inability to intervene in time to guarantee safety.

Third, in some instances, ongoing experiences of victimization may produce long-term manifestations of emotional numbing, extreme passivity, and helplessness. As levels of threat and violence escalate, women's perceptions of their options for escaping from the violence become increasingly restricted, and choosing one of these options may seem too dangerous to pursue. If the perceived threat of abuse once the woman leaves is greater than the anticipated abuse if she stays in the relationship, a woman may develop survival rather than escape skills and focus on strategies to mediate or dissociate from the violence.

Given the severity of threats against leaving made by many abusers and the possibility of severe or even lethal reprisals, it is not surprising that so many women

victims do not to leave the relationship, instead hoping for improvement and opting for a danger that is known rather than one that is unknown. If a woman lacks adequate financial resources, and leaving her abuser means living in unsafe housing in a crime-ridden community, leaving her abuser may only change the type of danger to be faced while adding the risk of assaults by strangers to the risk of her partner's reprisals.

Recovery from the Trauma of Partner Abuse and Violence

Can Women Recover from Partner Abuse?

A few studies have suggested that negative psychological responses to physical violence and threat may improve once the survivor is no longer in danger. For some women victims, however, removing themselves from a dangerous situation may not be sufficient. Without effective therapeutic intervention, some survivors continue to experience chronic depression, withdrawal, and posttraumatic stress disorder years after becoming free of a violent relationship.

Programmatic Interventions to Decrease Partner Violence and Assist Women

A variety of critical services currently exist for abused women, most of which were founded by grass-roots or advocacy movements – including safe houses for women victims and their children, crisis lines, support groups, and legal services. However, most of these services are seriously underfunded and hard-pressed to deal with the large numbers of women and children needing assistance.

Recommendations

Treatment Needs

My recommendations for a public health initiative to raise public awareness will focus on educating health and mental health personnel about the nature of domestic violence, how to identify the symptoms of partner abuse, and how to direct a woman toward appropriate treatment and services. A woman seeking health or mental health services may present symptoms that are consistent with a variety of causes, one of which is battering. If service providers are unaware that battering may be a cause of the woman's symptoms, they are unlikely to ask the woman whether she has been a victim of intimate violence, let alone to initiate appropriate interventions. Intervention goals for women victims of violence include the attainment of a safe environment and physical and psychological health. In order to attain these goals, mental health interventions should include:

1. *Routine screening for histories of victimization.* Such screenings should take into account issues of privacy, confidentiality, and safety for women in making disclosures. Practitioners conducting screenings should have previously established links with resources for protection, shelter, legal aid, and other services that may be needed by victims or other family members.
2. *Validation of the experience.* An explanation that many women experience physical and sexual assault from intimate partners, that such assaults may lead

to a range of physical and psychological sequelae, that such assaults are illegal and inappropriate, and that a variety of resources exist for individuals who have experienced these assaults should accompany assessments of victimization, even if disclosures are not forthcoming. For many victims, such statements by a professional are a first step toward a new understanding of their abusive experiences and toward seeking intervention or counsel.

3. *Consideration of responses to trauma in diagnosis and treatment planning.* Knowledge that a woman has experienced traumatic events with the potential to cause a variety of post-traumatic responses should be taken into account in evaluations for diagnoses and in treatment planning.
4. *Safety planning with victims and survivors.* Women who are separated from abusive partners and women who are still with violent mates can benefit from careful assessment of their personal safety. Even when the abuser is no longer present, survivors of partner violence may still be at risk of re-assault or re-contact with that assailant. Formerly abused women may also have trouble assessing the safety of current relationships. Safety planning should include questions such as: does the woman need immediate police protection, legal intervention, or a safe shelter? Does she have an escape plan if the danger escalates? What should she do if her child is threatened?
5. *Expanded interventions for men who physically or sexually assault their female partners.* Dealing with the victims and survivors of violence by male partners is a first priority. However, enhanced interventions for abusive men must be developed if the number of abused women and traumatized children is to be reduced. Priorities include the development of mechanisms for early identification of abusive men when they are seen in mental health settings, improved interventions for creating and maintaining change in violent behavior, and strategies for engaging a wider population of abusive men in interventions for abusers.
6. *Expanded interventions for children and adolescents who have witnessed violence between adult caretakers.* Witnessing physical and sexual violence between adult caretakers in the home has profound and pervasive effects on children's and adolescents' development and well-being. Preventive interventions – too often exclusively focused on issues of physical safety – should be expanded to include treatment and ongoing support services for children who have been traumatized by witnessing assaults against their mothers or other female caretakers.

Research Needs

Along with treatment needs, it is equally important to continue research on the many aspects of domestic violence to ensure that the most effective interventions are developed. The following is a list of critical areas in need of further empirical assessment:

1. *The lifetime prevalence of violence by relational partners for single adult women, poor women, incarcerated women, and women from diverse racial and ethnic backgrounds.*

Definitions of what is considered abusive; perceived and actual alternatives to abuse; and meanings attached to violence, connectedness, and safety differ sharply across culture and other groups. These disenfranchised groups are typically underrepresented or almost completely missing from the past 15 years of survey research.

2. *The psychological effects of intimate violence in nationally representative samples of adult women.* Although national studies have documented the incidence and prevalence of assaults against women by male partners, no nationally representative studies exist on the psychological aftereffects of these assaults. Such studies are critical to inform clinical understanding of survivors' presentations and behaviors and to develop effective therapeutic treatments and supports. Systematic criteria are now being developed to assess the effects of physical and sexual assault on victims that might then guide clinical efforts to facilitate recovery.
3. *Contributing factors to the perpetration and maintenance of male violence against intimate partners.* Within psychology, our intense focus on why some women stay in abusive relationships has distracted us from advancing our understanding of the precursors and persistence of male violence against wives or other intimate partners. Even after a decade, we know relatively little about what leads some men to use physical aggression as a relational tool, the maintenance of aggression once abusive interactions have occurred, or the likelihood that aggression will escalate given separation or the threat of separation from the target. Prospective research on patterns of violence and factors that influence men to stop their violent behavior is vital - both as a basis for comprehensive evaluations of existing intervention strategies and for the design of more effective mechanisms for creating and maintaining change in men who direct violence against their adult intimates.
4. *Patterns of re-assault and threat for victims who leave their abusers or take other steps to end the aggression.* Although as a society we have fairly clear ideas of what a women "should" do if faced with violence in her relationship, we have relatively little knowledge about the *outcomes* for women victims who follow these societal prescriptions. Research is needed on the risks of re-assault, particularly lethal assault, for women who leave violent partners or who pursue legal alternatives, as well as on which alternatives or choices most effectively mitigate against further harm.
5. *Protective factors against partner violence by men and mechanisms for enhancing those factors in the lives of children and adolescents.* Although the prevalence and severity of family violence have been recognized for nearly two decades, almost no research has been conducted focusing on primary prevention. Prospective research is urgently needed to identify protective factors at various stages of development and to inform strategies for reaching an optimal number of at-risk children and adolescents.

Conclusions

The research on domestic violence has demonstrated that it is by no means a rare occurrence. Rather, it is a national public health problem that needs to be addressed immediately. Not only do many women victims of partner violence suffer physical injury as a result of the abuse, they suffer a range of adverse psychological outcomes as well. Unfortunately, too little is known about specific subpopulations of abused women, particularly ethnic minority women. And little is known about the effectiveness of the various interventions and services that currently exist to serve women victims of domestic violence.

It is clear that we need research on these issues, and that health and mental health personnel, including clinical psychologists and social workers, physicians and nurses, need to focus on identifying such victims early on and directing them toward appropriate treatment and services. In addition, we must pay attention to those who are victims of violence by association: to the children who witness violence between intimate partners. If we fail to attend to the needs of these children and if we fail to intercede and expose them to non-abusive, positive relationships, we will only be perpetuating the cycle of abuse we are desperately trying to stop.

Finally, we must take into account the fact that domestic violence is part of the larger issue of violence within our society. To the extent that we can reduce current levels of violence within the home through the treatment, research, and policy initiatives suggested by the Task Force, we may make significant strides towards reducing societal violence overall.

I appreciate the opportunity to offer testimony to the committee and would be pleased to answer any questions you may have.

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The testimony given today was drawn from the report of the APA's Task Force on Male Violence Against Women:

Koss, M.P., Goodman, L.A., Browne, A., Fitzgerald, L.F., Keita, G.P., & Russo, N.F. (1994). No Safe Haven: Male Violence Against Women at Home, at Work, and in the Community. Washington, D.C.: American Psychological Association.

Mr. TOWNS. Right. Let me thank all of you for your testimony. I think you have been very helpful. Let me begin, I guess, maybe with you, Dr. MacLeod. You know, some States are moving forward to say that domestic violence should be reported like child abuse.

What are your views on that in terms of the doctor-patient relationship?

Dr. MACLEOD. If I could answer that in two forms, and I think Dr. Salber may have some comments because the State of California does have required reporting. I think one of the major steps we have to make is beyond the victim of domestic violence with simply the physician.

This is going to have to be a team effort. Physicians alone are not going to be able to be the ones to identify. As we move into more capitated environments where there is going to be physician extenders involved, patients are going to be opening up to nurses, nurse practitioners, and all the health care practitioners that they intervene with or they talk to.

In terms of required reporting, I have some concerns that required reporting may, so to speak, throw the baby out with the bath water. In some States where it is being practiced right now, it may prevent people from coming to the department because they may be afraid that they would be reported, and that may put them at risk.

One of the most dangerous times, as we have seen in our national case, is that when there is a separation between the abuser, the abusive relationship. That is the most dangerous time physically, and to prematurely push that before the victim is ready to separate, I think, may be a dangerous situation. We try to keep all of our interactions with the focus on the victim's safety as a pre-eminent concern, which is why we do our assessment tool in private. We ask the abuser to leave, and then we ask the patient or the victim, are you ready for intervention?

If they are not, that is their choice we contact them later to maintain their safety because usually there is children involved. It is not only just themselves, and they have learned to survive in this environment now, and it is for them to decide. We give them the tools so that they can escape that environment.

Mr. TOWNS. Dr. Salber, did you want to comment further on that question?

Dr. SALBER. I did actually. The State of California has a new mandatory reporting law where physicians and other health care providers must report documented or suspected abuse to the police whether the patient wants it or not.

I have grave concerns about what that does to the physician-patient interaction. You try and establish a relationship with a woman and encourage her to talk about a difficult issue, and somewhere along the line you have to say, whether you like it or not, I have to report it to the police.

The second issue is the issue that Dr. MacLeod brought up, which is that we may be placing this woman at greater risk because we have no assurance just because we make the police report that any effective police intervention will take place, and there may be retaliation by the batterer on the woman when he finds out she has reported.

Then, finally, although I can't give you statistical evidence, what we are starting to see—our law went into effect in January, and what we are starting to hear from the shelter in my county are women calling up the shelter and saying, "I was injured, but I am not going to go to the emergency department because I don't want it reported to the police."

Mr. TOWNS. That becomes counterproductive then.

Dr. SALBER. Right.

Mr. TOWNS. When you look at it, you wonder whether you should continue to pursue it. Dr. Campbell, that there is the school of thought that the nurses have more contact with the patients than the doctors, and that the nurses should be involved in the reporting process. What are your views on that?

Ms. CAMPBELL. Well, I agree with the other two speakers in terms of mandatory reporting being a serious problem, and our position, my own and the American Nurses Association position, is that this needs to be a team effort, and that everyone in each health care system needs to be alert for domestic violence, needs to do the questioning.

We also have to keep in mind that these are adult women who will choose who they disclose to. They may choose a nurse, they may choose a physician, they may choose to disclose to the social worker or to the ward clerk for that matter, so that these are adult women, and it is their choice as far as who they want to talk to about this problem.

We feel that each health care setting needs to have all the professionals get together, come up with a coordinated response, a way of screening which may be appropriate in one emergency department, may be different like at a prenatal clinic, but that every adult woman be screened for domestic violence, and then that interventions be taken appropriately, and it depends on the setting, and sometimes in terms of the reimbursement just who is the appropriate person to do the actual long-term intervention.

In some emergency departments there is social workers available that may take over on the intervention part. We also want to make sure and give women choices, though. She may want to speak, continue to speak to that physician or to that nurse and not see a social worker, so we want to give her as many options as we can as far as how she continues.

In some cases, it may be beneficial to her, she may want the health care provider to call the police, but it should be her choice, and her choices and her safety, as was said, need to be our paramount concerns. I also wanted to mention in terms of prevention that settings like school health clinics is a very important arena that we can assess for domestic violence, dating violence kinds of situations early and do some early interventions. Also, public health nursing with home visits. Again, the providers need to be more fully aware about domestic violence and make it a part of their standard of care.

Mr. TOWNS. When you talk of legislation, you have to look at all sides, all angles, then when you finish doing that, you still may have missed a lot of key points. Dr. Goodman, they say that children learn what they live, so if it is a violent situation and children are in it and exposed to it on an ongoing basis, if the children come

forward and say that this is an abusive situation, this is what is going on, does that carry any weight at all? How would you deal with that?

For instance, you have a situation here where it is very obvious that there is abuse, but the spouse does not want to come forward, but the child comes forward. What do you do with information like that?

Dr. GOODMAN. I think that example highlights the need for more training of not only health professionals, but teachers in schools and social workers and other people who might be the recipients of such information. I think that often people have no idea what to do with it and they need more training on how to sensitively explore the situation without endangering the child who is often also a victim of violence in a household in which a man is abusing his wife or his partner.

Mr. TOWNS. How about for the medical profession, if a child comes in with his mother, his mother is not prepared to talk to you about it, but the child says, you know, really what mommy says is not accurate, you know, daddy really punched her. She really didn't get hit by a door. How do you deal with situations like this?

Because when we talk about legislation you have to make certain that these kind of factors are also considered. If not, you end up missing the real point which is making certain that people are safe and don't have to go through this kind of abuse. I would like to hear your comments on that.

Dr. SALBER. I will comment on this first. I think, again, we have to come back to the idea that all health care providers need to be trained and become comfortable in dealing with the issue, no matter who brings it forward to them. One of the things that we have done at my hospital, at Kaiser-Permanente in south San Francisco, is to form an interdepartmental domestic violence committee. We invited the pediatricians, the social workers, the employee assistant personnel, the clergy, people from the shelter community, the emergency department, the internists, everybody sits on this committee, and we are trying to all educate ourselves to understand the violence and the context in which it is happening.

At my medical center, the child would most likely be seen by a pediatrician. This committee has helped to educate our pediatrician that he needs to think about the mother of the child he is seeing as well as the child himself, and it has been very helpful, but I agree with Dr. Goodman that education of the provider is key.

Dr. MACLEOD. Specifically, Mr. Chairman, you have chosen a very complex situation. It is almost where we have been successful ahead of ourselves. For example, you could imagine how that child may have learned that in school. We may have done some program about prevention in school, and then the child realizes what is going on at home isn't the right thing, then says something.

Meanwhile, we haven't gotten to the victim, and we certainly haven't gotten to the batterer then how do you address that issue? Frankly, that is a very specific—you know, we have to be careful. It is like when we roll out all of our prevention strategies, you have to have the resources to be able to handle them. Actually, what would you do in that situation, that is going to be very hard. It is almost like you would have to get the family together and hope

that there would be insight and that you wouldn't be inflaming the situation.

It was actually—that situation happened on the new show “ER” actually where it was, if everybody remembers, they actually came up and the wife denied it and then you just saw the family leave to a very frightening possibly dangerous environment, and that could happen where suddenly the victim says, no, it didn't really happen and the batterer says, no, it didn't happen, and you are left with a child and you don't know who to believe, and you can't really do anything. Then what?

I wish I could say, do this, but I don't think in that situation—that is a very complex one. Of course, you had to pick a hard one.

Ms. CAMPBELL. These children are definitely at risk, and they are not only at risk for health care problems; they have both emotional and physical health care problems. These children are also highly at risk to become violent themselves as adults, and this is a population that we could target with programs.

Now, again, we need some testing of what interventions would be useful for these children. Most of the wife abuse shelters provide programs for these kids, but it is a 30-day kind of setting, and there is no systematic follow-up in terms of when they go into their regular schools, what kinds of things are done for them there, but those kinds of programs definitely could be and really should be mandated that these are a group of kids highly at risk, both short-term and long-term, and that built on the model that is used in the shelters could be perhaps done in schools, just like there are groups in schools that meet with counselors around if they are children of divorce or children of substance abuse kinds of families.

This kind of thing could be done, and, obviously, the issues of confidentiality and safety have to be addressed extremely carefully, but there are a lot of good thinkers out there that have been working with these kids for a long time in domestic violence programs, and that is certainly the group we need to target for interventions.

Some of the courts that work with batterers that do sentencing of batterers to batterer treatment, mandated batterer treatment kinds of programs are starting to take into account the children, and also mandate and figure out a way to fund some counseling sessions for those children.

Mr. TOWNS. Let me ask you, has there been any real follow-up on children coming out of abusive situations, any data to say what happens to them in terms of their behavior.

Ms. CAMPBELL. As far as I know there have not been any long-term studies of the children of battered women. There have been some short longitudinal studies, but not any following them all the way to adulthood, but what we do know is that when we take groups of batterers, men who abuse their wives, that they are more likely, that having seen abuse in their childhood is a risk factor for them becoming abusive. It doesn't explain all of it, not every child that grows up in an abusive home becomes a batterer, but it is definitely a risk factor in study after study, so we do know that.

Dr. SALBER. There is currently a study that is in process, the investigator is Cathy Spatz Widom from SUNY in New York. She has followed longitudinally children who have been abused and neglected, and her preliminary data show, confirm the increased inci-

dence of violent behaviors in these individuals, both within the family and outside the family.

Mr. TOWNS. I think it was you, Dr. Campbell, who said that people who are involved in domestic battery should not be allowed to carry a weapon.

Ms. CAMPBELL. It was I.

Mr. TOWNS. I want to support it, and I think it makes a lot of sense, but I think the problem is how do we identify.

At what point, do we say we are convinced that you are doing committing battery and should not carry a weapon.

Ms. CAMPBELL. Well, if a man has been arrested for domestic violence, especially if he is convicted, but even an arrest, there must be some sort of probable cause. It makes sense that that home is a very volatile one, and almost all of those domestic homicides involve a handgun, and it makes sense that that home is not a good place for there to be a gun.

Also in terms of a man has an order of protection out against him, this has gone through the courts, he has had a chance to respond, to prove that this shouldn't be—there should not be an order of protection against him, but if this has gone through the courts and it has been signed by a judge, then, again, this is not a safe man to be having a handgun, and this is not the kind of home where a handgun needs to be until the domestic violence situation is resolved.

Mr. TOWNS. Suppose it is a situation where the police have been called to this particular home three times, and it is very obvious when you look at it that there is something going on, but the wife will not prosecute.

What would your position be on removing a weapon in a situation where there is no prosecution or conviction?

Ms. CAMPBELL. In most jurisdictions now, like you said, if it is clear that something is going on, if there is abuse going on, then that officer has probable cause in order to make a domestic violence arrest. In most jurisdictions in the United States if he has probable cause, an arrest is recommended in those kinds of cases. What I am saying is if there is enough evidence for an arrest, there is enough evidence to take that gun out of the house.

Mr. TOWNS. Let me just ask one other question. I know you are not a lawyer, but you are everything else, so I feel comfortable asking you. Suppose there is a situation where a person that is being abused will say to the police, well, you know, we are going to work it out, don't arrest him.

Ms. CAMPBELL. In terms of the weapon?

Mr. TOWNS. Yes. How do we deal with that? I am concerned about that weapon, I will be honest with you. That is the reason I am asking all those questions, and I am from New York so you know I am concerned about the weapon.

Ms. CAMPBELL. I do know in Detroit, for instance, I have worked with the police department in Detroit, and there is sort of an unofficial kind of thing in that city that in those kind of cases the police would use their judgment call and remove the gun sort of unofficially, but what they would like to have is more of an official ruling, more of an official law that this is OK and that this is indicated, and I think what we would need is the input of police offi-

cers and legal counsel in terms of exactly how that would be worded, but the intent to get the gun out of that house makes perfectly good sense, and it just needs to be backed up that police officers have that kind of leeway to make those kinds of judgments, and all of the police jurisdictions that I have worked with and I have worked with many, are very much in favor of being able to do that. They just feel like in a lot of jurisdictions that their hands are tied.

Mr. TOWNS. Yes, Dr. MacLeod.

Dr. MACLEOD. Just a comment. I think the handgun is important, but even in our most publicized case now that doesn't take away all the weapons. I think as important would be what does the police do with that first call where they are sent away?

Is there a process in place, as with child abuse, where you have a children and youth services activated? Is there a process where domestic violence advocates are activated and then contact that house to try to assess the situation, to safely identify whether there is something they can do. Because I think if the person isn't killed, the violence will continue.

There should be a program where the police officer is able to activate a cascade of intervention or contacts that are done to that house to see if there is anything to prevent any further violence before killing. I think that would be something that should be in place. I feel that people who feel they will have something to do besides keep being sent there and being sent away.

Mr. TOWNS. I think you, Dr. Salber, mentioned the team effort—who heads the team? Who calls the meeting and moderates whatever goes on? Who is the leader?

Dr. SALBER. In my hospital, it was myself and a psychologist who initiated this, but really anybody can do it who has the interest. One of the things that we hope to be able to do is to increase awareness of this kind of model for other hospitals and emergency departments, but really it doesn't require a physician or an emergency physician particularly to be the leader of the team. It requires somebody with interest and a responsiveness on the part of hospital administration to institutionalize that kind of team.

Dr. MACLEOD. In our hospital, it is our domestic violence advocate who is actually an employee of the shelter who functions in our hospital, and she is the one. The interdisciplinary team was in place but she organizes it. There is representation from the hospital administration, physicians, nurses, obstetrics and gynecology, trauma, everybody is represented, pastoral care, social work, and so it works as an interdisciplinary team. She is actually the chairman and runs the show, I think the point is it doesn't have to be a physician. It should be someone who has the interest and is willing to spend the time doing it.

Ms. CAMPBELL. But what is clear, is it does need institutional support. There needs to not only be the interest and the commitment from the providers, but there also has to be the support from administration and also the mechanisms to pay for this kind of care. One of the things we are concerned about in terms of health care reform is will there be reimbursable kinds of categories around domestic violence that don't require that the woman get a psychological diagnosis. It may be a diagnosis of PTSD or depression is appropriate, but what about for the woman who does not

get that psychiatric diagnosis. Will there be any mechanism to reimburse providers to continue to care for her and her children in that kind of preventive safety kind of concerned way, and that is one of the issues that we are particularly concerned about.

Mr. TOWNS. My last question.

You know, I think that most of the emphasis, what we are hearing here in the Congress is let us do something in terms of women who are battered, and I think that is important. I think we should, and I think we must do more. But I think at the same time we are not stressing the fact that the people who are doing it, I don't think that we are spending enough time on men that have a tendency to abuse. I think that there should be some programs on their behalf as well as trying to intervene and stopping the violence. We cannot deal solely with the female.

So I think we need some programs for males. I would like to get any of your views on that.

Dr. SALBER. I agree with you. I think it is extremely important, and as I said, we included this in our recommendations to the CDC. The problem is that we need a lot of information before proceeding with intervention. We need to understand more in detail about risk factors. When we do make recommendations for intervention, we need to study them and evaluate them and be sure that they work.

For example, the overall recidivism rate of men who go through batterers treatment programs is very high. The success rate is rather low, but some programs do have successes. We need to take a look at those and see what was different about those successful programs compared to the ones which weren't successful in order to develop better models, but I think it is extremely important that we focus on intervention and hopefully prevention of battering by men.

Ms. CAMPBELL. I absolutely agree. One of the issues is that most of our batterer treatment models are based on a very seriously abusive man who has been arrested and mandated into batterer treatment. What we don't have good models on is what about after the first push or shove because we are going to—if we identify men at an earlier point in the abuse stream, what works for them, and that we don't know.

We also know that, for instance, young men who are unemployed, this is a risk factor for domestic violence. We need to provide for young men a way for them to feel like they really meet the manhood requirements of this society without having to beat a woman, and that is a very important issue, both in terms of talking to young men, programs on transition to manhood, including a component on gender relationships, conflict resolution programs in our schools need to also have a component on gender conflict, not just male-male kinds of conflict, so that these issues are brought to the attention, and then we need to do some structural reform in this society so that young men do have real opportunities because we can't just arrest and incarcerate abusive men, that is not—that is a dead end eventually. We need to come up with some creative ways to deal with this.

Dr. MACLEOD. I have three young children, when I get into a stressful moment with my kids I revert back to what my father did

to me, even though I say I will never do that, and it is things I say, and I find that that, to me, is the most telling evidence that people are taught that violence is a way to solve interpersonal relations or difficulties. If they see that when they grew up, that is what they are going to revert to in times of stress.

I think there has to be an even more fundamental change at a societal level that shows people that is not what it is all about, that there is a difference. I think sometimes batterers don't even know that what they are doing is wrong because that is the way their granddad did it, and that is the way their dad did it, and they did it back in the old country. And to break that is a very fundamental change.

If you look at old TV shows you will see the people smoked and never wore seat belts. Now you watch TV and people wear seat belts and don't smoke. We need to see changes that are about that.

They talk about contraception and protective changes. That is the kind of changes where domestic violence doesn't have the stigma that we usually assess to it. I guess it goes back to whether you fundamentally believe that people are good or bad. I believe that batterers batter because that is probably in large part a learned behavior. You have to break with a learned behavior. If you have looked at any of the studies, they show that learned behaviors are very deeply ingrained. That is probably why there is such recidivism in those treatment programs. They are very strong and they are very hard to break because that is what they are taught in response to stress so I have no solutions to that.

Mr. TOWNS. I thank all of you for your testimony and really think you have been extremely helpful. It is a very difficult issue, and that I think that in order to come up with a solution it is going to require teamwork, team effort as you put it, and I think that we would have to be a part of that team as well. We must make certain that legislation that comes out of here really helps.

You have been very helpful to us in terms of our decision here. I apologize for the delays and apologize again for my colleague who was down there trying to protect our legislation. The subcommittee is now concluded.

[Whereupon, at 1:50 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

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Opening Statement
Rep. Donald Payne
Subcommittee on Human Resources and
Intergovernmental Relations
Hearing: "Domestic Violence As a Public
Health Issue"
October 5, 1994

Good Morning. Mr. Chairman, I would like to commend you for calling this hearing today. Also, I want to extend my regards to the witnesses who have agreed to provide us with their testimony.

With the advent of the O.J. Simpson murder trials, there is a national focus on the larger issue of domestic violence. And as witnessed by the nation, domestic violence occurs in homes without regard to race, ethnicity, or socio-economic status. The psychological impact of domestic abuse remains with its victims throughout their lifetimes, long after the physical evidence of the abuse wears off.

More than one million women are impacted by domestic violence each year. The cost of these violent incidents to the nation's trauma centers and hospital emergency rooms is fueling the cost of the our health care system, because nearly a third of emergency room admissions are the result of domestic battery.

And although 99% of domestic assaults do not result in the death of the victim, many women not only suffer physical trauma, but the mental and emotional trauma of living in fear for their lives.

I want to again commend Chairman Towns for his leadership in confronting this issue, because domestic violence is a public health issue as well as a criminal justice issue.

Recovery for the victim is long and slow when they do manage to escape and most pass this tragic legacy from one generation to the next.

Thank you Mr. Chairman, and I look forward to the testimony of our witnesses.

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